

# **APPENDICES**

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# **Appendix 1:**

## **SFY 2006 Funding Allocations**

(Tracy Luoma will hand this out at the AP Training workshop)  
Next two pages are blank.





**Appendix 2:**

**Components of a Service  
or  
Program Description**

## **Appendix 2:**

### **Components of a Service or Program Description**

The following are brief definitions of the requested components to be included in a service or program description. Most definitions are followed by a series of “ticklers” or prompts suggesting information to include under each component of the description. It should be noted, the ticklers are intended as helpful hints, and are not identifying information, reports, or data that needs to be submitted to the Division of Substance Abuse and Mental Health. If a component (1-9 below) of the Program Description does not apply to a Treatment Program Area, indicate with “Not Applicable”.

- 1) **General Description of Service or Program:** Describe generally what the contracted service; support, or project is intended to do or accomplish.
  - (a) What are the major goals of the program?
  - (b) Who will be receiving services under this program?
  - (c) Is the program co-ed?
  - (d) What type of program is being provided, e.g. residential or non-residential?
  - (e) What are the hours the program must be in operation?
  
- 2) **Description of the population to be served:** Describe the client or population to be served by the Provider. Include enough detail and specific assessment criteria to demonstrate the match between the target population and the Provider's services or supports.
  - (a) Are there specific eligibility requirements?
  - (b) Are there specific age requirements?
  - (c) Gender requirements?
  - (d) Intellectual functioning requirements?
  - (e) Mental health/substance abuse requirements?
  - (f) Clients who are not eligible for this service?
  - (g) Does the provider have discretion to deny services to clients?

**Appendix 3:**

**Minimum Evaluation  
Requirements for Prevention  
Services**

# **MINIMUM EVALUATION REQUIREMENTS FOR PREVENTION SERVICES**

## **INDIRECT SERVICES**

### **Media Campaigns, Public Service Announcements, Press Releases**

#### **Minimum Evaluation**

- Provide documentation of efforts at annual site review **(FY 05)**
  - News clippings, press releases, videotapes, reach and frequency of ad or PSA, etc.

### **Social Norms Marketing**

- Pre/post test results of attitudes and use rates in electronic format.
- Provide documentation of efforts at annual site review
  - Examples of posters, media efforts, reach and frequency, etc.

### **Retailer Trainings**

#### **Minimum Evaluation**

- PATS information **(FY 05)**
  - Demographics, Hours
- Provide documentation of topics covered at annual site review **(FY 05)**
  - Agendas, handouts, etc.

### **Retailer Compliance Checks (Synar/Alcohol buys)**

#### **Minimum Evaluation**

- Completed Synar data sheets for tobacco inspections **(FY 05)**
- Provide documentation of efforts at annual site review for alcohol checks **(FY 05)**
  - Buy/compliance rates
  - Number of checks done
  - Number of reward letters/citations issued

### **Trainings**

These could be teacher or community trainings where there is no funding responsibility or oversight for the resulting implementation of the program being trained.

#### **Minimum Evaluation**

- PATS information **(FY 05)**
  - Demographics, Hours
- Provide documentation of topics covered at annual site review **(FY 05)**
  - Agendas, handouts, etc.

## **DIRECT SERVICES**

### **One-time Events**

These are events that are held for large groups or communities of people such as a school-wide assembly, health fair or community-wide event.

#### **Minimum Evaluation**

- PATS information **(FY 05)**
  - Demographics, Hours
  - Exact count if possible, on demographics
  - Estimates based on community or group if exact count is not possible
    - This information could be gathered from census.gov, school data, etc.
    - There will be an estimate box to check in PATS and field to enter what the estimate was based on.

### **Classes**

These are classes that have a stable roster; are time-limited; have a set curriculum; and a defined entry and exit.



### **Minimum Evaluation**

- Multiple Sessions checked in PCAPI **(FY 05)**
- PATS information **(FY 05)**
  - Demographics, Hours **OR**
  - Clients checked in PCAPI and attendance kept
- Pre/Post tests (matched if possible)
  - Include appropriate risk/protective factor scales based on the expected outcomes listed in the logic model
  - Other questions may be required based on the Federal PPG guidelines
  - This information will be submitted electronically to the State (format to be determined)

### **Drop-In Programs**

These are programs that do not have a set roster. Participants come and go as they please. Some examples would be tutoring centers, after-school programs, etc.

### **Minimum Evaluation**

- PATS information **(FY 05)**
  - Demographics, Hours
  - May be aggregated over 30 days and reported monthly
  - Demographics can be estimated or collected via a sign-in sheet

### **Youth Coalitions**

#### **Minimum Evaluation**

- Provide documentation of efforts at annual site review **(FY 05)**
  - Planning, youth implemented programs, press releases, etc.
- PATS information **(FY 05)**
  - Demographics, Hours

### **Open-Entry/Exit Classes**

These are classes where the curriculum is in set modules, but the participants may start at any point and then stay until they have completed a full cycle.

### **Minimum Evaluation**

- Multiple Sessions checked in PCAPI **(FY 05)**
- PATS information **(FY 05)**
  - Demographics, Hours **OR**
  - Clients checked in PCAPI and attendance kept
- Pre/Post tests (matched if possible)
  - Pretest at attendee's first session
  - Post-test at attendee's last or second to last module
  - Include appropriate risk/protective factor scales based on the expected outcomes listed in the logic model
  - Other questions may be required based on the Federal PPG guidelines
  - This information will be submitted electronically to the State (format to be determined)

### **Mentoring**

This is a one-on-one or small group long-term relationship. The emphasis is on the relationship building and bonding.

### **Minimum Evaluation**

- PATS information **(FY 05)**
  - Demographics, Hours
  - Reported for mentees and PEER mentors
- Pre-tests
  - Of mentees to assess risk level
  - Mentors, if they are peers (youth)
  - This information will be submitted electronically to the State (format to be determined)

- Post-tests
  - Administered to mentees and PEER mentors
  - Towards end of relationship period or annually, which ever is sooner.
  - This information will be submitted electronically to the State (format to be determined)

### **Peer Court**

These standards assume that the Local Authority is working primarily in the training of the youth judges.

### **Minimum Evaluation**

- PATS information for training of judges **(FY 05)**
  - Demographics, Hours

### **Counseling**

These are programs such as BSFT or FFT. These clients cannot have a DSM-IV diagnosis for a substance abuse disorder, or treatment funds must be used instead of prevention funds.

### **Minimum Evaluation**

- PATS information **(FY 05)**
  - Demographics, Hours
- Matched Pre/Post tests
  - Include appropriate risk/protective factor scales based on the expected outcomes listed in the logic model
  - Other questions may be required based on the Federal PPG guidelines
  - This information will be submitted electronically to the State (format to be determined)

## **OTHER SUGGESTED EVALUATION METHODS**

### **INDIRECT SERVICES**

#### **Media Campaigns, Public Service Announcements, Press Releases**

- Logs of interest generated, calls received, web hits, etc.
- Ad recall surveys
- Focus groups on content

#### **Retailer Trainings**

- Satisfaction surveys
- Pre/post knowledge gain

#### **Retailer Compliance Checks (Synar/Alcohol buys)**

- Archival data (juvenile stats)
- PNA – perceived availability
- Resources devoted to spot checks of signs

#### **Trainings**

- Knowledge gain surveys
- Evaluation of teaching skills
- Survey of how likely the trainees are to use the training
- Satisfaction survey
- Follow-up survey to see how many trainees are implementing the training

### **DIRECT SERVICES**

#### **One-time Events**

- Post-only satisfaction surveys
- Calls generated, web hits, etc if literature is handed out.

#### **Classes**

- Tracking of topics covered
- Knowledge gain questions on pre/post tests

- Fidelity of program
  - Documentation of changes in intended population
  - Documentation of changes in curriculum
- Match of pre-tests to community RF/PF profiles to see if the program has the “right” participants
- School attendance/grades outcomes
- Discipline referrals
- Parent observation/feedback
- Instructor observation/feedback

### **Drop-In Programs**

- Satisfaction survey after session
- First/last session questionnaire
- Parent/teacher observation of behavior
- School-wide surveys of awareness or use of program

### **Youth Coalitions**

#### **Other Suggested Evaluations**

- Pre/Post of attitudes and pro-social involvement
- Awareness surveys at school
- Parent surveys
- Teacher observations
- GPA, referrals, attendance, etc.

### **Open-Entry/Exit Classes**

- Tracking of topics covered
- Fidelity of program
  - Documentation of changes in intended population
  - Documentation of changes in curriculum
- Match of pre-tests to community RF/PF profiles to see if the program has the “right” participants
- School attendance/grades outcomes
- Discipline referrals
- Parent observation/feedback
- Instructor observation/feedback

### **Mentoring**

- GPA, attendance, referrals, etc.
- Annual follow-up and/or periodic review of relationship
- Records of activities (scrapbooks)
- Exit survey with termination reason
- Pre/post of waiting list
- Satisfaction survey of adult mentors

### **Peer Court**

- Any information the local would like to collect on the kids that are referred to the peer court

### **Counseling**

#### **Other Suggested Evaluations**

- Referral source
- Reason for referral
- Parent/teacher observations
- Changes in school performance

# **Appendix 4:**

## **Prevention Funding Requirements**



## Appendix 4:

# Prevention Funding Requirements

## Overview

### Federal SAPT Block Grant

SEC. 1922(b) ALLOCATION REGARDING PRIMARY PREVENTION PROGRAMS – PUBLIC LAW 102-321

- υ The State will expend not less than 20 percent for programs for individuals who do not require treatment for substance abuse, which programs educate and counsel the individuals on such abuse; and provide for activities to reduce the risk of such abuse by the individuals.
- υ The State will give priority to programs for populations that are at risk of developing a pattern of such abuse; and ensure that programs receiving priority develop community-based strategies for the prevention of such abuse, including strategies to discourage the use of alcoholic beverages and tobacco products by individuals to whom it is unlawful to sell or distribute such beverages or products.

### State General Fund

SEC. 17-43-201(4)(a) and (b) - UTAH CODE

- υ Each local substance abuse authority shall:
  - ⌘ review and evaluate substance abuse prevention and treatment needs and services; and
  - ⌘ annually prepare and submit to the division a plan for funding and service delivery that includes: provisions for services, either directly by the substance abuse authority or by contract, for adults, youth, and children, including those incarcerated in a county jail or other county correctional facility; and primary prevention, targeted prevention, early intervention, and treatment services.

### Governor's Safe and Drug Free Schools and Communities Funding

SEC. 4112. RESERVATION OF STATE FUNDS FOR SAFE AND DRUG-FREE SCHOOLS.

- υ Funds shall be used to implement drug and violence prevention activities, including:
  - ⌘ Activities that complement and support local educational activities, including developing and implementing activities to prevent and reduce violence associated with prejudice and intolerance;
  - ⌘ Dissemination of information about drug and violence prevention; and
  - ⌘ Development and implementation of community-wide drug and violence prevention planning and organizing.
- υ Programs and activities should meet the principles of effectiveness described in section 4115(a).
- υ Priority shall be given to programs and activities that prevent illegal drug use and violence for:
  - ⌘ Children and youth who are not normally served by State educational agencies or local educational agencies; or
  - ⌘ Populations that need special services or additional resources (such as youth in juvenile detention facilities, runaway or homeless youth, pregnant and parenting teenagers, and school dropouts).
- υ Special consideration shall be given to pursuing a comprehensive approach to drug and violence prevention that includes providing and incorporating mental health services related to drug and violence prevention.

## **SAPT Block Grant**

### **45 CFR 96 – Subpart L – Substance Abuse Prevention and Treatment Block Grant**

#### **96.125 Primary Prevention.**

- a. Each State/Territory shall develop and implement a comprehensive prevention program, which includes a broad array of prevention strategies directed *at individuals not identified to be in need of treatment*. The comprehensive program shall be provided either directly or through one or more public or nonprofit private entities. The comprehensive primary prevention program shall include activities and services provided in a variety of settings for both the general population, as well as targeting subgroups who are at high risk for substance abuse.
- b. In implementing the prevention program the State shall use a variety of strategies, as appropriate for each target group, including but not limited to the following:
  1. **Information Dissemination**: This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco and drug use, abuse and addiction and their effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:
    - i. clearinghouse/information resource center(s);
    - ii. resource directories;
    - iii. media campaigns;
    - iv. brochures;
    - v. radio/TV public service announcements;
    - vi. speaking engagements;
    - vii. health fairs/health promotion; and
    - viii. information lines.
  2. **Education**: This strategy involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g. of media messages) and systematic judgment abilities. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:
    - i. classroom and/or small group sessions (all ages);
    - ii. parenting and family management classes;
    - iii. peer leader/helper programs;
    - iv. education programs for youth groups; and
    - v. children of substance abusers groups.
  3. **Alternatives**: This strategy provides for the participation of target populations in activities that exclude alcohol, tobacco and other drug use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco and other drugs and would, therefore, minimize or obviate resort to the latter. Examples of activities

conducted and methods used for this strategy include (but are not limited to) the following:

- i. drug free dances and parties;
  - ii. youth/adult leadership activities;
  - iii. community drop-in centers; and
  - iv. community service activities.
4. Problem Identification and Referral: This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:
- i. employee assistance programs;
  - ii. student assistance programs; and
  - iii. driving while under the influence/driving while intoxicated education programs.
5. Community-Based Process: This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, inter-agency collaboration, coalition building and networking. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following:
- i. community and volunteer training; e.g., neighborhood action training, training of key people in the system, staff/officials training;
  - ii. systematic planning;
  - iii. multi-agency coordination and collaboration;
  - iv. accessing services and funding; and
  - v. community team-building.
6. Environmental: This strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. This strategy is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those which relate to the service and action-oriented initiatives. Examples of activities conducted and methods used for this strategy shall include (but not be limited to) the following:
- i. promoting the establishment and review of alcohol, tobacco and drug use policies in schools;
  - ii. technical assistance to communities to maximize local enforcement procedures governing availability and distribution of alcohol, tobacco and other drug use;
  - iii. modifying alcohol and tobacco advertising practices; and
  - iv. product pricing strategies.

# **Governor's Safe and Drug-Free Schools and Communities Funding**

## SEC. 4112. RESERVATION OF STATE FUNDS FOR SAFE AND DRUG-FREE SCHOOLS.

### (a) STATE RESERVATION FOR THE CHIEF EXECUTIVE OFFICER OF A STATE-

(1) IN GENERAL- The chief executive officer of a State may reserve not more than 20 percent of the total amount allocated to a State under section 4111(b) for each fiscal year to award competitive grants and contracts to local educational agencies, community-based organizations (including community anti-drug coalitions) other public entities and private organizations, and consortia thereof. Such grants and contracts shall be used to carry out the comprehensive State plan described in section 4113(a) through programs or activities that complement and support activities of local educational agencies described in section 4115(b). Such officer shall award grants based on —

(A) the quality of the program or activity proposed; and

(B) how the program or activity meets the principles of effectiveness described in section 4115(a).

(2) PRIORITY- In making such grants and contracts under this section, a chief executive officer shall give priority to programs and activities that prevent illegal drug use and violence for —

(A) children and youth who are not normally served by State educational agencies or local educational agencies; or

(B) populations that need special services or additional resources (such as youth in juvenile detention facilities, runaway or homeless children and youth, pregnant and parenting teenagers, and school dropouts).

(3) SPECIAL CONSIDERATION- In awarding funds under paragraph (1), a chief executive officer shall give special consideration to grantees that pursue a comprehensive approach to drug and violence prevention that includes providing and incorporating mental health services related to drug and violence prevention in their program.

(4) PEER REVIEW- Grants or contracts awarded under this section shall be subject to a peer review process.

(5) USE OF FUNDS- Grants and contracts under this section shall be used to implement drug and violence prevention activities, including —

(A) activities that complement and support local educational agency activities under section 4115, including developing and implementing activities to prevent and reduce violence associated with prejudice and intolerance;

(B) dissemination of information about drug and violence prevention; and

(C) development and implementation of community-wide drug and violence prevention planning and organizing.

(6) ADMINISTRATIVE COSTS- The chief executive officer of a State may use not more than 3 percent of the amount described in paragraph (1) for the administrative costs incurred in carrying out the duties of such officer under this section.



## **Principles of Effectiveness**

### SEC. 4115. AUTHORIZED ACTIVITIES.

#### (a) PRINCIPLES OF EFFECTIVENESS-

(1) IN GENERAL- For a program or activity developed pursuant to this subpart to meet the principles of effectiveness, such program or activity shall —

(A) be based on an assessment of objective data regarding the incidence of violence and illegal drug use in the elementary schools and secondary schools and communities to be served, including an objective analysis of the current conditions and consequences regarding violence and illegal drug use, including delinquency and serious discipline problems, among students who attend such schools (including private school students who participate in the drug and violence prevention program) that is based on ongoing local assessment or evaluation activities;

(B) be based on an established set of performance measures aimed at ensuring that the elementary schools and secondary schools and communities to be served by the program have a safe, orderly, and drug-free learning environment;

(C) be based on scientifically based research that provides evidence that the program to be used will reduce violence and illegal drug use;

(D) be based on an analysis of the data reasonably available at the time, of the prevalence of risk factors, including high or increasing rates of reported cases of child abuse and domestic violence; protective factors, buffers, assets; or other variables in schools and communities in the State identified through scientifically based research; and

(E) include meaningful and ongoing consultation with and input from parents in the development of the application and administration of the program or activity.

#### (2) PERIODIC EVALUATION-

(A) REQUIREMENT- The program or activity shall undergo a periodic evaluation to assess its progress toward reducing violence and illegal drug use in schools to be served based on performance measures described in section 4114(d)(2)(B).

(B) USE OF RESULTS- The results shall be used to refine, improve, and strengthen the program, and to refine the performance measures, and shall also be made available to the public upon request, with public notice of such availability provided.

(3) WAIVER- A local educational agency may apply to the State for a waiver of the requirement of subsection (a)(1)(C) to allow innovative activities or programs that demonstrate substantial likelihood of success.

## **Appendix 5:**

### **SFY 2006 DSAMH QA Site Review Schedule**

**FY 2006 CALENDAR FOR LOCAL AUTHORITY REVIEWS**  
**Contract Monitoring Master Calendar FY06 (7/1/2005 - 6/30/2006)**

PROVIDER	MH Adult Q of Care Review	MH Child Q of Care Review	SA TX Review	SA Prevention and SICA Review	SA Justice Review	G & O Data Review	Final Report Sent to LA & directors
Bear River DOH LSAA	N/A	N/A	Sep 12 - 16, 2005				10/17/05
Central Utah - Six Co. SA/MH	Oct 3 - 7, 2005						11/7/05
Bear River MH LMHA	Oct 17 - 21, 2005		N/A	N/A	N/A	10/17-21/05	11/21/05
Southwest Center SA/MH	Oct 31- Nov 4, 2005						12/5/05
Summitt (VMH) SA/MH	Nov 14 - Nov 18, 2005				N/A	11/14-18/05	12/19/05
SLCo. LMHA - VMH	Dec 5-9, 2005		N/A	N/A	N/A	12/7-8/05	1/9/06
SLCo. LSAA	N/A	N/A	Dec 5 - 9, 2005			11/30/2005	1/9/06
Tooele Co. (VMH) SA/MH	Jan 9 - 13, 2006						2/13/06
Utah Co. LSAA	N/A	N/A	Jan 30 - Feb 3, 2006				3/3/06
Utah Co. (WMH-SSD) LMHA	Feb 13 - 17, 2006		N/A	N/A	N/A	2/13-17/05	3/17/06
Davis Co. DBH SA/MH	Mar 6-10-2006						4/10/06
Four Corners SA/MH	Mar 27-31, 2006						5/1/06
Weber HS SA/MH	Apr 3 - 7, 2006						5/8/06
San Juan SA/MH	Apr 24-28, 2006						5/29/06
Northeastern SA/MH	May 8 - 12, 2006						6/12/06
Weber HS SA/MH	May 22-26, 2006						6/26/06
DSAMH Responsible Staff	Robert Snarr	Ming Wang & Kathleen Smart	Victoria Delheimer	Craig Povey	Brent Kelsey	QA & Research Teams	

Notices will be mailed one month prior to the visits.

## **Appendix 6:**

# **Site Review Monitoring Instruments**

# ADULT MONITORING TOOL (Chart Review Instrument)

PSC: \_\_\_\_\_ PSC Unit #: \_\_\_\_\_

Unit Staff: \_\_\_\_\_ Unit #: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Age: \_\_\_\_\_

A&D Diagnosis: \_\_\_\_\_ A&D Dates: \_\_\_\_\_

ID# \_\_\_\_\_ Date: \_\_\_\_\_

Client Name: \_\_\_\_\_

		Y	N	N/A	Comments
<b>ASSESSMENT SECTION</b>	1. a. Is the Assessment complete, including adequate documentation of the diagnosis?				
	b. Is the client's name, ID#, date, time, duration, and unit # included on each page?				
	c. Is it signed by a Licensed Supervising Professional?				
	2. a. Were additional evaluations completed as indicated (e.g. psychological testing, psychiatric evaluation, assessment for medical condition), supporting the diagnosis?				
	b. Did the diagnosis change?				
	c. If so, has a Diagnosis Update Form been completed?				
	d. If the client is A&D fee-for service, does Axis I include an A&D diagnosis?				
	3. Does the psychiatric evaluation contain diagnosis and plan for medication?				
	4. Is the Case Management Needs Assessment (acuity scale) completed for clients identified as need/receiving CM services?				
	5. Does the chart contain the ASI (Assessment Severity Index) for A&D fee-for-service pts.?				
6. Has the SPMI/SED form been completed?					
<b>MANAGED CARE PLAN/REVIEW</b>	7. a. Do the Managed Care Plans (MCP) list all methods utilized?				
	b. Is the # sequence clear?				
	c. Is the MCP signed by a Licensed Supervising Professional, as appropriate?				
	d. Was the client able to sign as a participant in developing goal(s)?				
	e. Is the desired change statement realistic and relevant?				
	8. Has the ASAM for A&D fee-for-service client been completed to include:				
	a. dimension level ratings?				
	b. documentation when admission level does not match criteria level?				
	c. signatures and titles?				
	9. a. Does the Review(s) address progress towards desired change?				
	b. Do the review dates fall within the required review schedule: 90 days: <input type="checkbox"/> Medicare <input type="checkbox"/> Case Mgmt <input type="checkbox"/> A&D Day Tx <input type="checkbox"/> YIC 180 days: <input type="checkbox"/> Medicaid <input type="checkbox"/> A&D Adult <input type="checkbox"/> Other				
	c. Are reviews signed by a Licensed Supervising Professional, as appropriate?				
	d. Has the ASAM been reviewed along with the MCP A&D desired change? 1 month: Residential 3 months: Day Tx/Intensive Outpatient 6 months: Outpatient				

<b>MEDICAL SECTION</b>	10.	Are the medical progress notes complete to include:				
	a.	SOAP or SIP format, time, duration, method?				
	b.	current medications?				
	c.	clear documentation of subsequent changes and review of medications?				
	d.	signature and title?				
	11.	Has the med mgt protocol form been completed?				
	12.	Has the client been seen by a prescriber in the past 3-6 months?				
			<b>Y</b>	<b>N</b>	<b>N/A</b>	<b>Comments</b>
<b>PROGRESS NOTES/DOCUMENTATION</b>	13.	Are the progress notes complete to include:				
	a.	date, time, duration, method (for case management, include location)?				
	b.	relationship of services to MCP desired change goals?				
	c.	clear documentation of interventions made and justification for continued treatment?				
	d.	documentation addressing A&D abuse or dependence monthly (A&D FFS clients)?				
	e.	SIP format for individual therapy and individual behavior management?				
	f.	narrative for Case Management and Creative Intervention?				
	g.	signature and title?				
	14.	Are group and SDS monthly summaries complete to include:				
	a.	date, time, duration, method?				
	b.	progress toward desired change?				
	c.	documentation addressing A&D abuse or dependence (A&D FFS clients)?				
	d.	weekly group notes for fee-for-service clients?				
	e.	signature and title?				
	15.	Were progress notes written in response to information learned in electronic communications (email)?				
<b>CONTINUITY OF CARE</b>	16.	Do the assessment, diagnosis, managed care plan, reviews, and progress notes/monthly summaries reflect consistent flow of clinical information?				
	17.	Is the Continuity of Care form being used appropriately?				
	18.	Has the patient been seen during the past three months? If not, is there justification for keeping the chart open (e.g., meds only)?				
	19.	Does the chart as a whole clearly document reasons for interventions selected to reach the treatment objectives and continued need for treatment?				
<b>OTHER</b>	20.	Does the filing sequence follow an approved outline?				
	21.	Is the chart legible?				
	22.	Are the A&D MIS admission and discharge forms completed on County A&D clients, when applicable?				
<b>Additional comments:</b>						
<b>Reviewed by:</b>						

# UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

## Children And Youth Quality Of Care Review Chart Review Checklist

Preferred Practice Guidelines: Assessment And Treatment Of Children And Youth

Center: \_\_\_\_\_ Site: \_\_\_\_\_ Center Designee: \_\_\_\_\_

Division Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_

### Chart Information

ID #: \_\_\_\_\_ Medicaid: ☐ Yes ☐ No

Age: \_\_\_\_\_ Gender: ☐ Male ☐ Female

### Current Diagnosis:

AXIS I: \_\_\_\_\_

AXIS II: \_\_\_\_\_  
\_\_\_\_\_

AXIS III: \_\_\_\_\_

AXIS IV: \_\_\_\_\_

AXIS V: \_\_\_\_\_

Special Concern: \_\_\_\_\_

Key Stakeholders	Check If Involved
DCFS	
DSPD	
SCHOOL	
DWS	
HealthCare Provider	
Juvenile Court	
Probation/ Youth Corrections	
Foster Parent	

### Assessment

Observed	Not Observed	NA	Preferred Practice Guideline
			1. Assessment identifies:
			1a- possible assessment instruments
			1b- reason for referral & present concerns (nature of concern/duration/frequency/circumstances/consequences)
			2. Initial diagnosis
			2a- is based on assessment information
			2b- is the basis for treatment goals and strategies
			2c- is reviewed regularly
			3. Diagnosis adheres to DSM and considers co-morbid conditions, atypical presentations, V codes, and deferred/provisional diagnoses
			4. Care giver(s) is/are primary source of information
			5. Evidence of communication with other significant individuals or entities (schools, health care providers, court, ...)

			6. Assessment information includes:
			6a- developmental milestones, including receptive and expressive languages
			6b- psychiatric history
			6c- medical history, including vision and hearing problems
			6d- school functioning, performance, formal testing
			6e- emotional development and temperament
			6f- peer relations
			6g- family relationships
			6h- strengths, interests, and hobbies
			6i- unusual family or environmental circumstances
			6j- parental/Family medical and psychiatric history
			6k- substance use of child
			6l- traumatic circumstances, including child abuse, domestic violence, and family substance abuse
			6m-legal involvement
			6n- mental status exam
			7. Assessment accomplished in culturally sensitive manner, considering linguistic needs, socio economic factors, family structure, religious practices, geographic location, immediate community and other factors

### Treatment Planning

Observed	Not Observed	NA	Preferred Practice Guideline
			1. Family members or caregivers provide input and are involved in treatment plan development, implementation, and evaluation
			2. Treatment goals and strategies
			2a- are collaboratively derived
			2b- address reasons for referral
			2c- address needs of child/youth in daily functions at home and family, in school/child care, in the community or other environments
			3. Treatment plan is individualized and considers
			3a- cognitive, developmental, and personally differentiating characteristics of child
			3b- unique family characteristics and cultural customs
			3c- community expectations and environmental demands (including child care/school standards)
			4- Treatment plan identifies indicators of progress including time frames
			5. Family therapy is considered
			6. Crisis/Safety plan is included or addressed
			7. Frequency of services is age and diagnostically appropriate and flexible
			8. Treatment setting is accessible, child/family friendly, and representative of natural environment
			9. Wraparound services include
			9a- Non-traditional services
			9b- Collaborative consultation
			9c- Parents are provided information on parent support organizations, and parent education/training
			10. Treatment plan identifies contact person for coordination within agency and with other services
			11. Regular review dates for supervisory input indicated
			12. SED Eligibility Determined
			12a-Form in folder
			12b-Evidence of regular review and Reflects current status of child/youth
			13. Progress Notes are current and regularly reviewed
			14. Information is shared among clinical and psychiatric staff



**UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH**  
**QUALITY OF CARE REVIEW AND TECHNICAL ASSISTANCE**  
**PARENT INVOLVEMENT AND PERCEPTION OF**  
**SERVICES INTERVIEW FORM**

11/18/03

Community Mental Health Center: \_\_\_\_\_

Site: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ Interviewer: \_\_\_\_\_

Parent(Optional): \_\_\_\_\_ Interview Conducted: In person \_\_\_\_ By telephone \_\_\_\_

Specify Relationship of Person Interviewed to Child/Youth (e.g., mother, foster mother, etc.):

\_\_\_\_\_ Age of Child/Youth: \_\_\_\_\_ Sex: M F

Source of Payment (Optional): Medicaid \_\_\_\_ CHIP \_\_\_\_ Private Insurance \_\_\_\_\_

Length of Time Child/Youth Has Been Served by Center: \_\_\_\_\_

Please help improve services by answering some questions about the services that your child and you have received. Your answers will be kept confidential. Please indicate the response that most closely reflects your experiences.

STATEMENT	Does Not Apply	Not True At All	Mostly Not True	Undecided	Mostly True	Very True	Comments
1) Before coming to the Center, I felt "blamed" for my child's difficulty.							
2) When I recognized that my child needed help, I knew whom to contact.							
3) Center staff are courteous to me and my family and treat us with respect.							
4a) Center staff talked with me about the need to get information from other people who work or are involved closely with my child.							
4b) Center staff asked me to sign a form: "A Release of Information" so they could get information directly from other people who work with my child.							
5) When I first came in and talked to staff here at the Center, I felt listened to.							
6) I only had to "tell my story" one time.							
7) There was not a long delay between the time I first called the Center and the time I was able to see someone about my child.							
8) All the forms that I was asked to complete and sign were reviewed with me by Center staff.							
9) Center staff adequately reviewed my involvement in the evaluation, diagnosis, and treatment of my child.							

STATEMENT	Does Not Apply	Not True At All	Mostly Not True	Undecided	Mostly True	Very True	Comments
10) Center staff explained the kinds of services and programs that are available to my child at the Center.							
11) Staff explained and reviewed the Center grievance procedure with me.							
12) I was asked for information about how my child was doing:							
a) at home in our family and with family members;							
b) in school (child care);							
c) in other places we regularly go, such as church, stores, etc.							
13) I feel the information I gave was valued and used in the evaluation, diagnosis and treatment of my child.							
14) I am aware that my therapist has contacted other people who work with my child to gather information used in the evaluation, diagnosis, and treatment of him/her.							
15) The therapist answers my questions and discusses the evaluation and treatment effectiveness results with me.							
16) The therapist answers my questions and discusses the diagnosis of my child with me.							
17) My child's therapist and I discuss how my child's diagnosis and treatment might affect him/her:							
a) at home with family members;							
b) at school (child care);							
c) in other settings.							
18) My child's therapist and other Center staff who work with my child have discussed treatment options, medications, and a range of services available to my child with me.							
19) The consequences of these options, including medications, are discussed with me.							
20) I was given brochures and materials to read about my child's condition.							Who gave those to you? Center, family organization, school, etc.
21) Information about parent groups that might be helpful was provided to me.							Who provided this information to you?
22) I was provided information about other sources to find out more about my child's condition.							List other sources.
23) I know the people who provide treatment for my child.							
24) I feel the people who provide the treatment for my child listen to me and use my feedback.							
25) My child is listened to by the people who work with him/her.							

STATEMENT	Does Not Apply	Not True At All	Mostly Not True	Undecided	Mostly True	Very True	Comments
26) The people who work with my child ask me about how my child is doing:							
a) at home with family;							
b) at school (child care);							
c) in other places we regularly go.							
28) My child's treatment plan and services are meeting his/her identified needs.							
29) I meet regularly with the people who work with my child.							
30) I feel that I am an active partner in my child's treatment.							
31) There is someone at the Center I can contact for crisis, concerns, or questions.							
32) That person gives me assistance when I need it.							
33) People at the Center who work with my child ask for feedback on a regular basis about the effectiveness of the treatment plan.							
34) On a regular basis, center staff ask for feedback from other people who work with my child in other agencies about the effectiveness of his/her treatment.							
35) I am involved in any changes in treatment or services for my child.							
36) I have been offered a copy of my child's treatment plan.							
37) I have a copy of my child's treatment plan.							
38) My child's treatment plan includes a plan for crisis situations.							
39) People who work with my child are helping me gain the skills and information my family and I will need to help my child maintain his/her emotional well-being.							
40) My child's therapist and others who work with my child help me and my family look to his/her future needs.							
41) I feel the people at the Center who work with my child are friendly and genuinely concerned about my child and family.							
42) Transportation to appointments and services is not a problem for my family and me.							

My child and family are getting these services from the Mental Health Center:

*Possible list (Check those that apply)*

☐ Evaluation    Comment:

---

☐ Individual Therapy    Comment:

---

☐ Group Therapy    Comment:

---

☐ Family Therapy    Comment:

---

☐ Respite    Comment:

---

☐ In-home Assistance    Comment:

---

☐ Case Management    Comment:

---

☐ Mentoring (other names)    Comment:

---

☐ Skill Development    Comment:

---

☐ Day Treatment or Partial Day Treatment    Comment:

---

☐ Medication Management    Comment:

---

☐ Parenting Classes    Comment:

---

Are there services you need that you are not receiving? What are they? (Specify)

What has helped you and your child the most?

What difficulty have you had in getting mental health services? Please explain.

What barriers have you and your child encountered?

**OVERSIGHT MONITORING REPORT**  
**UTAH DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH**  
**REPORT DATE: \_\_\_\_\_**

CONTRACT NUMBER: \_\_\_\_\_ REVIEW DATE: \_\_\_\_\_

CONTRACTOR NAME: \_\_\_\_\_

LOCAL AUTHORITY: \_\_\_\_\_

MONITOR NAME: \_\_\_\_\_

AUDIT AREA: Prevention \_\_\_ Substance Abuse \_\_\_ Justice \_\_\_ MH Adult \_\_\_ MH Child \_\_\_ GAO \_\_\_

**PROGRAM STRENGTHS:**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

**PROGRAM PROBLEM AREAS:**

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.

## PERFORMANCE DEFICIENCIES:

A. MAJOR DEFICIENCIES (Imminent harm; recommend immediate initiation of a Corrective Action Plan [CAP] to achieve compliance within 24 hours.)

### Performance Deficiency

### Contract Provision/Policy Standard

(Completion of this information is not necessary UNLESS form is used as a working document.)

- 1.
- 2.
- 3.

- 1.
- 2.
- 3.

CAP Due Date: \_\_\_\_\_

Compliance Due Date: \_\_\_\_\_

B. SIGNIFICANT DEFICIENCIES (Recommend Corrective Action Plan be completed within 10 Days and compliance be achieved within 30 day.)

- 1.
- 2.
- 3.

- 1.
- 2.
- 3.

CAP Due Date: \_\_\_\_\_

Compliance Due Date: \_\_\_\_\_

C. MINOR DEFICIENCIES (Recommend Corrective Action Plan be completed within 30 days and compliance be achieved within 60-90 days.)

- 1.
- 2.
- 3.

- 1.
- 2.
- 3.

CAP Due Date: \_\_\_\_\_

Compliance Due Date: \_\_\_\_\_

\_\_\_\_ **IMMEDIATE SANCTION APPLIED:** (Please Attach Documentation Identifying Sanction.)

## DSA/MH PREVENTION MONITORING TOOL FY2005

Contractor Name: \_\_\_\_\_

SICA Contract Number #: \_\_\_\_\_ Block Grant Contract # \_\_\_\_\_  
Date \_\_\_\_\_

**Codes: Y = Yes, In Place, N = No, Not In Place, IP = In Progress, NA= Not Applicable**

	Monitoring Issue/Area	Rating (Y/ N / IP / NA)				Comments:
<b>STEP 1: COMMUNITY READINESS and MOBILIZATION</b>						
1.	What communities have been targeted for prevention?					
2.	Provide minutes of prevention advisory group meetings, including participants/ agencies/ job titles					
3.	Does your Prevention Advisory Group plan for all community prevention services?	Y	N	IP	NA	
4.	When was the last Key Leader survey completed?					
5.	How do you involve the community in planning for prevention services?					
6.	How do you educate the community about prevention services/efforts?					
7.	How do you promote prevention in your area?					
8.	What other committees/ coalitions have been used to help with the prevention efforts?					
9.	Are all Prevention Advisory Group members trained in the Risk and Protective Factor Model?	Y	N	IP	NA	
<b>Step 2 &amp; 3: Needs Assessment &amp; Prioritizing Risk Factors</b>						
10.	Were archival and SHARP Survey data reviewed by the Prevention Advisory Group?	Y	N	IP	NA	
11.	Did the Prevention Advisory Group review any additional community data?	Y	N	IP	NA	
12.	When was the last time you prioritized your risk and protective factors?					
<b>Step 4: Resource Assessment</b>						
13.	Do you maintain a current resource directory?	Y	N	IP	NA	
14.	How do you avoid duplication of prevention services?					
15.	Were programs modified to meet prevention needs?	Y	N	IP	NA	
<b>Step 5: Targeting Prevention Efforts</b>						
16.	What percentage of your Block grant money is spent in each of the IOM classifications?	Universal Selective Indicated				
17.	How are you addressing cultural issues with your universal interventions?					
<b>Step 6: Best Practices</b>						
18.	Were science-based programs or strategies identified to address the prioritized risk/protective factors?	Y	N	IP	NA	
19.	What science based programs outside of SICA are you using?					
20.	Have ineffective programs and strategies been eliminated or modified?	Y	N	IP	NA	

	Monitoring Issue/Area	Rating (Y/ N / IP / NA)				Comments:
21.	How have you sustained SICA programs?					
<b>Step 7: Evaluation</b>						
22.	What are the procedures to determine if goals and objectives were met annually?					
23.	Are you in compliance with eval guidelines as posted by the evaluation work group?	Y	N	IP	NA	
24.	Are logic models developed for each of your programs/services ?	Y	N	IP	NA	
25.	Does your agency track <b>ALL</b> prevention program participants with the PATS system?	Y	N	IP	NA	
26.	Are you evaluating prevention program effectiveness on an ongoing basis?	Y	N	IP	NA	
27.	Who is in charge of prevention records and where are the records kept ?					
<b>BUDGET</b>						
28.	Was 20% of the Block Grant funding spent on Prevention Services?	Y	N	IP	NA	
29.	Was a minimum of 50% of SICA Funds spent on science based programs?	Y	N	IP	NA	
30.	Was the contracted amount of state general funding spent on prevention	Y	N	IP	NA	
<b>POLICIES</b>						
31.	How are you ensuring you are creating a comprehensive prevention strategy for your community?					
32.	Does your community have a shared vision of prevention?	Y	N	IP	NA	
33.	How is the local Substance Abuse Director involved in prevention planning and implementation?					
<b>TRAINING/REPORTS</b>						
34.	Are all prevention staff certified in Substance Abuse Prevention Specialist Training?	Y	N	IP	NA	
35.	Were SICA Semi-Annual and Sub-Recipient Checklists submitted by the due dates this year?	Y	N			
<b>SUSTAINABILITY</b>						
36.	What have you done to sustain SICA programs?					

CONTRACT MONITOR \_\_\_\_\_ (Signature)

\_\_\_\_\_ Date



## SUBSTANCE ABUSE TREATMENT CASE FILE REVIEW

### AGENCY:

<u>Confidentiality</u>						
Consent form found in file (only required if information released)						
Includes specific name or general designation of program permitted to make disclosure						
Name/title of individual or organization to which disclosure is made.						
Name of patient						
Indicates how much and what kind of info is to be disclosed						
Signature of patient and guardian if minor and date signed						
Statement that the consent is subject to revocation						
Date, event, or condition upon which the consent will expire if not revoked before.						
<u>Assessment</u>						
Interview with a licensed treatment professional						
ASI for adults						
Comprehensive, research-based instrument for youth (preferred)						
Evaluation and documentation of current and historical alcohol and other drug issues						
Evaluation and documentation of level of readiness for change						
Evaluation and documentation of medical issues						
Evaluation and documentation of legal issues						
Evaluation and documentation of employment issues						
Diagnosis of a substance abuse related disorder						
Assessment findings drive treatment plan and placement decisions						
Screening for co-occurring mental illness (preferred)						
Completed within 3 days of admission or 3 sessions (except detox)						
Signature of an appropriately licensed professional.						
<u>Treatment Plan</u>						
Treatment Plan completed within 3 days or 3 sessions (except detox)						
ASAM placement criteria documentation.						
Individualized plan correlating with the ASI and ASAM doc.						
Client Progress in reaching specified goals.						
Signature of an app. licensed professional on plan and reviews.						
Reviewed for con't. appropriateness (14 days for high intensity residential, 30 days low intensity, 60 days for IOP or Day TX, 90 days for general outpatient).						
Patient participation (preferred).						
<u>Progress Notes</u>						
Every contact documented (preferred).						
Consistent with assessment and treatment plan (preferred)..						
<u>Discharge Planning/Continuity of care</u>						
Discharge summary.						
Signature and title of an appropriately licensed professional.						
Referrals and follow-up care provided (preferred).						
<b>TOTAL YES</b>						
<b>TOTAL NO</b>						
<b>Comments:</b>						
<u>SAPT Compliance</u>						
Policies on women's treatment, incl. pregnant SA abusers	-	-	-			
Policies on priority populations incl. IV drug users	-	-	-			
Policies on TB Services	-	-	-			
Policies on Confidentiality	-	-	-			
Polices on prohibition of hypodermic needles	-	-	-			
Consumer Entry into the System						
Consumer satisfaction survey						

## JUSTICE SERVICES TREATMENT FILE REVIEW

**Provider:**

**Date:**

**Conducted by:**

**LSAA Staff**

### Confidentiality

Consent form found in file (only required if information released)

Includes specific name or general designation of program permitted to make disclosure

Name/title of individual or organization to which disclosure is made.

Name of patient

Indicates how much and what kind of info is to be disclosed

Signature of patient and guardian if minor and date signed

Statement that the consent is subject to revocation

Date, event, or condition upon which the consent will expire if not revoked before. (must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.)

### Assessment

Interview with a licensed treatment professional

ASI for adults

Comprehensive, research-based instrument for youth (preferred)

Evaluation and documentation of current and historical alcohol and other drug issues

Evaluation and documentation of level of readiness for change

Evaluation and documentation of medical issues

Evaluation and documentation of legal issues

Evaluation and documentation of employment issues

Diagnosis of a substance abuse related disorder

Assessment findings drive treatment plan and placement decisions

Screening for co-occurring mental illness (preferred)

Completed within 3 days of admission or 3 sessions (except detox)

Signature of an appropriately licensed professional.

## JUSTICE SERVICES FILE REVIEW

**Provider:**

**File Number**

**Date:**

**Conducted by:**

**Provider staff in attendance:**

### Treatment Plan

Treatment Plan completed

Treatment Plan completed within 3 days or 3 sessions (except detox)

ASAM placement criteria documentation.

Individualized plan correlating with the ASI and ASAM documentation.

Client progress in reaching specified goals.

Signature of an appropriately licensed professional on plan and reviews.

Patient participation (preferred).

Evidenced based interventions (preferred)

Reviewed for continued appropriateness (14 days for high intensity residential, 30 days low intensity, 60 days for IOP or Day treatment, 90 days for general outpatient).

### Progress Notes

Every contact documented (preferred).

Consistent with assessment and treatment plan (preferred).

### Discharge Planning/Continuity of care

Discharge summary.

Signature and title of an appropriately licensed professional.

Referrals and follow-up care provided (preferred).

**TOTAL YES**

**TOTAL NO**

**Comments:**

JUSTICE SERVICE STAFF INTERVIEW					
Drug Court Program					
Frequent court reviews (weekly or semi weekly to begin)					
Graduated sanctions and incentives					
Program requirements given to participants early?					
short time period between arrest and enrollment?					
Random drug tests?					
Frequent drug test (2 per week)					
Payment of fines fees is part of treatment					
Local evaluation plan					
Drug Court Treatment Episode Data (TEDS)					
<b>Goals</b>					
<b>Collaborative Interventions for Addicted Offenders (CIAO)</b>					
Interagency agreement?					
Random drug tests?					
Frequent drug tests					
Status reports					
<b>Performance measures</b>					
DRUG TESTING					
<b>Information provided by</b>					
<b>Client notification</b>					
Random or scheduled?					
Maximum time between notification and submission					
Frequency tapers with compliance?					
<b>Collection procedures</b>					
Written collection procedures?					
Whose employees perform collections?					
Supplies stored in secure area?					
Observed collections?					
Procedures in place to ensure sample integrity?					
GCMS confirmation?					
<b>Testing procedures</b>					
Test performed by?					
Testing Methodolgy ( Immuno Assay, On-site, Other)					
Adulteration check?					
Temperature check?					
Time samples stored prior to testing?					
Time samples stored post test if negative					
Time samples stored post test if positive					
<b>Chain of Custody</b>					
Appropriate chain of custody form?					
Form signed by client?					
Form signed by collector?					
<b>Records</b>					
Collector log					
Client name or identifying number					
Collection date					
Barcode number					
Scheduled or unscheduled collection					
Drugs or medication taken					
Collector's initials					
Drugs screened					
Test results					

## OVERSIGHT AND MANAGEMENT CHECK LIST

Contractor Name: \_\_\_\_\_

Contract Number #: \_\_\_\_\_ Date \_\_\_\_\_

Ratings: P = pass F = fail NA = not applicable

Monitoring Issue/Area	Rating (Pass / Fail / NA)			Comments:
1. The Local Authority reviews and evaluates mental health, treatment, intervention, and prevention needs and services, including needs for incarcerated individuals 17-43-201(4)(a) (Board Minutes/Interview)	P	F	NA	
2. The Local Authority or its contracted provider prepare and submit an annual plan to the division for funding and service delivery through the Local Authority. 17-43-201(4)(b)	P	F	NA	
3. The Local Authority approves the annual budget (November for calendar year, May for fiscal year). 7A-1-410 Uniform Fiscal Procedures Act (Board Minutes/Interview)	P	F	NA	
4. The Local Authority selects an independent auditor. 17-43-201 (2)(c)(ii) (Board Minutes/Interview)	P	F	NA	
5. The Local Authority receives and reviews financial reports on a regular basis providing sufficient oversight and control of public funds allocated for programs and services.	P	F	NA	(e.g. quarterly financial reports, expenditure detail monthly report, program/service expenditure reports, funding revenue stream breakout report). Board minutes/Interview
7. There is a consistent pattern of Local Authority approval of special expenditures as specified in Local Authority policy (e.g. over \$500). See Board Bylaws and Center Policies	P	F	NA	
8. The Local Authority reviews and approves expenditures, and reimbursements of directors, officers and other agency staff. 62A-15-110(1)(b)(i) (Board Minutes/Interview)	P	F	NA	
9. The Local Authority annually certifies they have reviewed the independent audit. 62A-15-110(1)(d) (Certification of Audit Review & Board Minutes)	P	F	NA	
10. The Local Authority reviews Division reviews/audits. (Board Minutes/Interview)	P	F	NA	
11. The Local Authority takes corrective action when they know of a violation. 17-43-203(3) (Board Minutes/Interview)	P	F	NA	
12. The Local Authority annually contracts with the Division to provide substance abuse services. 17-43-201(4)(h) (Review Contract prior to audit)	P	F	NA	
13. The Local Authority appoints directly or by contract a part time or full time director for substance abuse and mental health programs and prescribes the director's duties 17-43-201(4)(d) (Board Minutes/Interview)	P	F	NA	
14. The Local Authority provides input and comment on new and revised policies established by the DSAMH board 17-43-201(4)(e) (Board Minutes/Interview)	P	F	NA	
15. The Local Authority established mechanisms allowing for direct citizen input 17-43-201(4)(g) (Board Minutes/Interview)	P	F	NA	
16. The Local Authority complies with all applicable state and federal statutes, policies, audit requirements, contract requirements, and any directives resulting from those audits and contract requirements 17-43-201(4)(i)	P	F	NA	
17. The Local Authority charges a fee for substance abuse and mental health services – exception: inability to pay circumstances 17-43-204(1) (Interview)	P	F	NA	
18. The Local Authority pays for the cost of services for persons residing in their jurisdiction 17-43-204(2) (Interview)	P	F	NA	

CONTRACT MONITOR

(Signature)

Date

**\*INDEPENDENT AUDIT**

Contractor Name: \_\_\_\_\_

Contract Number #: \_\_\_\_\_ Date \_\_\_\_\_

**Ratings: P = pass F = fail NA = not applicable**

Monitoring Issue/Area	Rating (Pass / Fail / NA)			Comments:
1. Audit was conducted according to UC-51-02a (Audits of political subdivisions, interlocal organizations, and other local entities).	P	F	NA	
2. Audit was conducted in accordance to OMB Circular A-133 (Audits of states, local governments, and non-profit organizations) and the audit report was received by DHS.	P	F	NA	
3. State auditor guidelines were followed for auditing the compensation and expenses of officers, directors, and specified persons	P	F	NA	All are referred to in DHS-9 and DHS-10 Auditors Guidelines
4. State auditor guidelines were followed for auditing and the funding is being used in accordance with the contracts.	P	F	NA	
5. State auditor guidelines were followed for auditing that, where applicable, the 20% county match was met.	P	F	NA	
6. State auditor guidelines were followed for auditing that required policies are in place.	P	F	NA	
7. State auditor guidelines were followed for auditing that all funding partners were invited to pre and exit audit conferences.	P	F	NA	
8. State auditor guidelines were followed for determining if the local authorities have established in writing that the Division may examine the entity's financial records, the county auditor may examine the entity's financial records, and the entity will comply with all directives by the Department of Human Services.	P	F	NA	
9. Executive Officers of the program provider meet with Local Authority members annually	P	F	NA	
10. DHS has received the Final Copy of the Independent Audit	P	F	NA	
11. DHS has received a copy of the management letter.	P	F	NA	
12. DHS has received a copy of the State Compliance Audit Report.	P	F	NA	
13. Interlocal Agencies have appointed required officials.	P	F	NA	

\_\_\_\_\_  
CONTRACT MONITOR (Signature)\_\_\_\_\_  
Date

Note: Check the independent audit report for compliance with the above.

**EVALUATION**  
(Monitor and evaluate programs/services)  
\*Items to be reviewed prior to the site review

Contractor Name: \_\_\_\_\_

Contract Number #: \_\_\_\_\_ Date \_\_\_\_\_

**Ratings: P = pass F = fail NA = not applicable**

Monitoring Issue/Area	Rating (Pass / Fail / NA)			Comments:
1. The Local Authority's Annual Plan prepared and submitted. * 17-43-201(4)(b) / 17-43-301(4)(a)(ii)	P	F	NA	
1A. Mental Health Plan: Includes provisions for a continuum of services either directly by the Mental Health authority or by contract for adults, youth and children, including those incarcerated in a county jail or other correctional facility. * 17-43-301(4)(b)(i)-(x)	P	F	NA	
1B. Substance Abuse Plan: Includes provisions for services either directly by the substance abuse authority or by contract for adults, youth and children, including those incarcerated in a county jail or other correctional facility and primary prevention, targeted prevention, early intervention, and treatment services. * 17-43-201(4)(b)(i)-(ii)	P	F	NA	
2. Mental Health CPEAR data submissions * Refer to contract and 62A-15-110(1)(e)	P	F	NA	
3. Substance Abuse TEDS, ASAM, ASI and PATS data submissions * Refer to contract and 62A-15-110(1)(e)	P	F	NA	
4. Information gathered in Mental Health clinical and best practice reviews Refer to contract	P	F	NA	<i>Adult and Child Clinical</i>
5. Information gathered in Substance Abuse site reviews Refer to contract	P	F	NA	<i>Treatment, Prevention and Criminal Justice</i>
6. Findings of Substance Abuse Peer Reviews *	P	F	NA	<i>UBHN(Richard Nance)</i>
7. Independent Audits * 51-02a	P	F	NA	<i>Prior Year</i>
8. Staff interviews: MH Adult____ MH Child____ SATX____ SAPX____ CJ____	P	F	NA	
9. Expenditure Reports * <b>General Ledger</b>	P	F	NA	
10. Does the center have a policy for client complaints/grievances? * Check Medicaid reports _____ DHS Contract Part I Section E(5)	P	F	NA	
11. Prior Years Monitoring Reports * Findings? Fill in Form L____ and check to see if the issues were resolved.	P	F	NA	
Establish and maintain either directly or by contract programs licensed under Title 62A, Chapter 2, Licensure of Programs and Facilities: Is license visibly posted? 17-43-201(4)(c) / 17-43-301(4)(a)(iii)	P	F	NA	
13. Local Authority Interviews (To be conducted following the site review)	P	F	NA	

CONTRACT MONITOR \_\_\_\_\_

(Signature)

\_\_\_\_\_

Date

# LOCAL AUTHORITY AND CONTRACTOR'S POLICIES

Contractor Name: \_\_\_\_\_

Contract Number #: \_\_\_\_\_ Date \_\_\_\_\_

Monitoring Issue/Area	Rating (Pass / Fail / NA)			Comments:
1. The Local Authority shall provide for the adoption of the following policies as already established by one of the participating counties or as approved by the legislative body of each participating county or interlocal board. 17-43-201-(2)(c)(iv)				Obtain a list of personnel who provided services under the MH and SA contract. Ask for Board minutes to see where each of the following policies was adopted. Audit to see if they follow their own policies in each area.
A. Administrative policies	P		NA	
B. Management policies	P		NA	
C. Financial policies	P		NA	
D. Procurement policies	P		NA	
E. Personnel policies	P		NA	
F. Clinical policies	P		NA	
2. The Contracted provider's policy adopts the following policies as already established by one of the participating counties or as approved by the legislative body of each participating county or interlocal board.				Review subcontracts to see if the center required the adoption of these policies with their subcontractors. Review their own audit records to see if they reviewed the subcontractors policy.
A. Administrative policies	P		NA	
B. Management policies	P		NA	
C. Financial policies	P		NA	
D. Procurement policies	P		NA	
E. Personnel policies	P		NA	
F. Clinical policies	P		NA	
3. The Local Authority establishes and requires contract providers to establish the following policies regarding substance abuse and mental health services and facilities in accordance with the policies of the DSAMH Board, and state and federal law 17-43-201(4)(f) / 17-43-301(4)(a)(vi)				This is for contracts that are NOT interlocal agreements.
A. Administrative policies	P		NA	
B. Management policies	P		NA	
C. Financial policies	P		NA	
D. Procurement policies	P		NA	
E. Personnel policies	P		NA	
F. Clinical policies	P		NA	
4. Provide input and comment on new and revised policies established by the board. *	P		NA	(See board minutes to see where/when LA provided input/comment) Check with Jan to see whom board policies are sent to. Are new Board policies sent to LA?
5. Comply with all applicable state and federal statutes, policies, audit requirements, contract requirements, and any directives resulting from those audits and contract requirements	P		NA	

CONTRACT MONITOR

(Signature)

Date

# LOCAL AUTHORITY CONTRACT WITH THEIR PROVIDER

Contractor Name: \_\_\_\_\_

Contract Number #: \_\_\_\_\_ Date: \_\_\_\_\_

The Local Authority Contract Language with their Provider, Sub-Contractor includes: (Monitoring Issue/Area 17-43-201/301(5))		Rating (Pass/Fail/ Not Applicable)			Comments:
1	Defined Contracting Parties	P	F	NA	
2	Defined Contract Period	P	F	NA	
3	Purpose and Scope of Work, Description of Services.	P	F	NA	
4	Compensation information –Contracted amount, how billing will occur and how payments will be made.	P	F	NA	
5	List of documents incorporated into contract by reference.	P	F	NA	
6	Insurance and indemnification requirements.	P	F	NA	
7	Compliance with all “applicable state and Federal laws” (i.e. included in DHS contract’s standard terms and conditions).	P	F	NA	
8	Complies with all requirements for the disclosure of lobbying activities.	P	F	NA	
9	Complies with all requirements for disclosure of conflicts of interests and third party transactions.	P	F	NA	
10	Complies with all board and division policies.	P	F	NA	
11	Comply with all requirements of Governance and Oversight legislation.	P	F	NA	
12	Requirements for record keeping, access to records, and reporting.	P	F	NA	
13	Modification and dispute resolution, including contract termination, and grievance procedures.	P	F	NA	
14	Financial reporting and accountability, including the type and frequency of providing financial reports and with applicable cost principles.	P	F	NA	
15	Approval by the Local Authority.	P	F	NA	
16	Compliance with all directives issued by DHS & DOH regarding use/expenditure of state and federal funds (i.e. backup documentation is provided with invoices)	P	F	NA	
17	Consults and coordinates with Local Authority with regard to programs and services.	P	F	NA	
18	Each entity receiving public funds from the LA agrees in writing the entity’s financial records and other records relevant to performance of the services provided shall be subject to examination by the division, LA director, county treasurer or county/district attorney	P	F	NA	

CONTRACT MONITOR \_\_\_\_\_ (Signature)

Date \_\_\_\_\_



**\*DIVISION CONTRACT WITH LOCAL AUTHORITY**

Contractor Name: \_\_\_\_\_

Contract Number #: \_\_\_\_\_ Date \_\_\_\_\_

Monitoring Issue/Area	Rating (Pass / Fail / NA)			Comments:
1. An independent auditor shall conduct an audit of the local substance abuse and mental health authority or its contract provider's programs or services.	P	F	NA	
2. The independent audit shall include an audit of the compensation and expenses of officers, directors, and specified employees of the private contract provider, to assure the State that no personal benefit is gained from travel or other expenses;	P	F	NA	
3. Requested information and outcome data will be provided to the division in the manner and within the time lines defined by the division	P	F	NA	
4. Contract states the local authority/ agency will comply with Title 17-43-201 Local Substance Abuse Authorities-Responsibilities and Utah Code 62A-15-105, and all rules promulgated there under by DHS/DSAMH or Contract states that the local authority/agency will comply with Title 17-43-301 Local Mental Health Authorities – Responsibilities and Utah Code 62A-15-110 and all rules promulgated there under by DHS/DSAMH	P	F	NA	
5. All entities receiving any public funds from a local authority agree in writing that the division and the county auditor may examine and audit the entity's financial records; 17-43-201/301(5)(a)-(c)	P	F	NA	
6. The Division may withhold funds otherwise allocated to the authority to cover the costs of audits, attorney's fees, and other expenses associated with reviewing the expenditure of public funds by a local authority or its contract provider if there is an audit finding or judicial determination public funds were misused by either the local authority or its contract provider.	P	F	NA	
7. The division may withhold funds for contract noncompliance; failure to comply with division directives regarding the use of public funds; misuse of public funds; and failure of a local authority's contract with a provider to comply with state and federal law or policy.	P	F	NA	
8. Local Authority shall invite and include all funding partners to the Independent Audit pre- and exit conferences. 62A-15-713(3) / 62A-15-110(1)(c)	P	F	NA	
9. Each member of the Local Authority shall annually certify that he has received the independent audit and has participated in a formal interview with the provider's executive officers 62A-15-713(4) / 62A-15-110(1)(d)	P	F	NA	
10. The Local Authority ensures that requested information and outcome data is provided to the DSAMH in the manner and within the timelines defined by DSAMH. 62A-15-713(5) / 62A-15-110(1)(e)	P	F	NA	
11. All audit reports by state or county persons or entities concerning the Local Authority or its contract provider shall be provided to the executive director of DHS, the Local Authority, and members of the contract provider's governing board 62A-15-713(6) / 61A-15-110(1)(f)	P	F	NA	
12. The Local Authority or its contract provider offered and provided mental health services to residents who are indigent and who meet criteria for serious and persistent mental illness or severe emotional disturbance. 62A-15-713(7)	P	F	NA	

CONTRACT MONITOR

(Signature)

Date

**\*AREA SERVICE PLAN**

Contractor Name: \_\_\_\_\_

Contract Number #: \_\_\_\_\_ Date \_\_\_\_\_

Monitoring Issue/Area	Rating (Pass / Fail / NA)			Comments:
1. Does the annual area plan outline a comprehensive continuum of services?	P	F	NA	
<p style="text-align: center;"><b>Mental Health / Substance Abuse</b></p> <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> Inpatient care &amp; services _____  Residential care &amp; services _____  Outpatient care &amp; services _____  24-Hour crisis care &amp; services _____  Psychotropic med. management _____  Community supports _____  Consultation &amp; education services _____  _____ </div> <div style="width: 48%;"> Universal Prevention _____  Selective Prevention _____  Indicated Intervention _____  Treatment _____  DUI _____  Screening and assessment _____ Educational Series _____  Utilized proceeds of DUI to supplement the cost of services _____ </div> </div>				
1. Are the following requirements met?	P	F	NA	
Substance Abuse Mental Health Service Plan was submitted according to established deadline _____ Services are provided for Adults _____ Children _____ Youth _____ Services are offered and provided to residents who are indigent (SPMI/SED) _____ There is an established mechanism for citizen input _____ Program Licenses are maintained as required _____ Commitment procedures and proceedings are appropriate _____ Written statement reflecting consumer's rights shared at intake _____				
Have outcomes and data been reported to the Division according to the requested deadlines? Data Outcomes Reports TEDS: 1 <sup>st</sup> Quarter _____ 2 <sup>nd</sup> Quarter _____ 3 <sup>rd</sup> Quarter _____ 4 <sup>th</sup> Quarter _____ Late _____ Errors _____ PATS: 1 <sup>st</sup> Quarter _____ 2 <sup>nd</sup> Quarter _____ 3 <sup>rd</sup> Quarter _____ 4 <sup>th</sup> Quarter _____ Late _____ Errors _____ MH: 1 <sup>st</sup> Quarter _____ 2 <sup>nd</sup> Quarter _____ 3 <sup>rd</sup> Quarter _____ 4 <sup>th</sup> Quarter _____ Late _____ Errors _____				
Have programs been monitored or reviewed? Does the program review indicate that public funds are spent consistent with services rendered for Substance Abuse and Mental Health purposes?	P	F	NA	
<div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> Adult Clinical Quality of Care review conducted _____  Children' Clinical Quality of Care Review conducted _____  Substance Abuse Treatment review conducted _____  Substance Abuse Prevention Review conducted _____  Criminal Justice Review conducted _____ </div> <div style="width: 48%;"> Report on File _____  Report on File _____  Report on File _____  Report on File _____  Report on File _____ </div> </div>				

CONTRACT MONITOR \_\_\_\_\_ (Signature)

Date \_\_\_\_\_

**FINANCIAL**

Contractor Name: \_\_\_\_\_

Contract Number #: \_\_\_\_\_ Date \_\_\_\_\_

**Ratings: P = pass F = fail NA = not applicable**

<b>Monitoring Issue/Area</b> <i>62A-15-103(2)(c)(v-viii)</i>	<b>Rating</b> <b>(Pass/Fail/NA)</b>			<b>Comments:</b>
<b>Onsite GAOC Review</b>				
1. Executive travel reimbursements reviewed	P	F	NA	
2. Executive reimbursements – general reviewed	P	F	NA	
3. General expenditures – personal gain reviewed	P	F	NA	
4. Surplus reviews	P	F	NA	
5. Inventory reviews	P	F	NA	
6. Third party transactions. Refer to DHS Contract	P	F	NA	
7. Conflict of interest. Refer to DHS Contract	P	F	NA	
8. Miscellaneous review based on Independent Audit findings	P	F	NA	
9. Designated treasurer made payments from moneys available for joint services upon audit of the appropriate auditing officer representing the county.	P	F	NA	
<b>Center Budget Officer Review: See Board minutes to audit this section</b>				
1. Budget officer review of monthly billings	P	F	NA	
2. Budget officer review of expenditures	P	F	NA	
<b>Substance Abuse / Mental Health Financial Review</b>				
1. Drug Treatment	P	F	NA	
2. Mental Health Treatment	P	F	NA	
3. Prevention	P	F	NA	
4. County Match (20%)	P	F	NA	
5. Review of Agency purchases	P	F	NA	

\_\_\_\_\_  
CONTRACT MONITOR (Signature)\_\_\_\_\_  
Date

**\*INTERLOCAL AGREEMENT**  
Monitoring / Review Form

Contractor Name: \_\_\_\_\_

Contract Number #: \_\_\_\_\_

Date \_\_\_\_\_

“Local Authority Interlocal Agreements” will include the following: (Utah Code Chapter 11-13)	Rating (Pass / Fail / NA)			Comments:
<b>1. <u>Treasurer:</u></b> Is designated from one of the participating counties; <b>or</b>  another person designated as the treasurer for the combined SA/MH authorities, and as the custodian of monies available for the joint services	P	F	NA	
<b>2. <u>Payments:</u></b> Treasurer <b>may make payments from the moneys for the joint services</b> upon audit of the appropriate auditing officer, or officers, representing the participating counties	P	F	NA	
<b>3. <u>Auditor:</u></b> Independent, or county, <b>auditor was appointed by</b> the Local Authority	P	F	NA	
<b>4. <u>Attorney:</u></b> A participating county designates a county, or district, attorney as the designated legal officer and appointed by the Local Authority	P	F	NA	
<b>5. <u>Joint SA/MH services provided:</u></b> The entity’s financial records, and other records relevant to the entity’s performance of the services provided, shall be <b>subject to examination by:</b> the designated treasurer, designated legal officer, the legislative body, and in a county with a county executive that is separate from the legislative body, the county executive or county auditor	P	F	NA	

CONTRACT MONITOR \_\_\_\_\_ (Signature)

\_\_\_\_\_ Date

\*Pre Review Form

## LOCAL AUTHORITY INTERVIEW GUIDE

Date \_\_\_\_\_

Local Authority member(s) Interviewed \_\_\_\_\_

LA Responsibilities	Comments:
1. The Local Authority reviews and evaluates mental health, treatment, intervention, and prevention needs and services, including needs for incarcerated individuals 17-43-201(4)(a) / 17-43-301(4)(a)(i)	How are the service needs determined for the population being served and what is your involvement in the process?
2. The Local Authority and/or its contracted provider develops and submits an annual plan to the division for substance abuse and mental health programs approved by the county legislative body 17-43-201(4)(b) / 17-43-301(4)(a)(ii)	What is your involvement in the formulation of the annual service plan? (Area Plan)
3. The Local Authority approves the annual budget. 17A-1-410 Uniform Fiscal Procedures Act	Is this necessary ? Could check Board Minutes and if not documented, then include in the interview.
4. The Local Authority selects an independent auditor or a county auditor. 17-43-201(2)(c)(ii) / 17-43-301(2)(c)(ii)	Is this necessary ? Could check Board Minutes and if not documented, then include in the interview.
5. The Local Authority receives and reviews financial reports on a regular basis (e.g. quarterly financial reports, expenditure detail monthly report, program/service expenditure reports, funding revenue stream breakout report).	Is this necessary for the interview? Could review Board Minutes, Board bylaws and Agency policies and if not documented, then include in the interview.
6. There is a consistent pattern of Local Authority approval of special expenditures as specified in Local Authority policy (e.g. over \$500). See Board bylaws and Agency policies	Is this necessary for the interview? Could review Board Minutes, Board bylaws and Agency policies and if not documented, then include in the interview.
7. The Local Authority reviews and approves expenditures and reimbursements of directors and other agency staff. 62A-15-110(1)(b)(i) / 62A-15-713(2)(A)	Is this necessary for the interview? Could review Board Minutes, Board bylaws and Agency policies and if not documented, then include in the interview.
8. The Local Authority annually certifies they have reviewed the independent audit. 62A-15-110(1)(d) / 62A-15-713(4)	How do you document your review of the independent audit and provide certification of the review? Do you participate in the entrance and exit interviews?
9. The Local Authority reviews Division reviews/audits.	Ask the commissioners response to the Divisions reviews and audits and their over all involvement in the process. (QA team to also review Board Minutes for verification)
10. The Local Authority takes corrective action when they know of a violation. 17-43-203(3) / 17-43-303(3)	What is your involvement in the corrective action process when you become aware of any violations in services?
11. The Local Authority has an internal quality assurance system to monitor their sub-contractor's performance at least annually and provides information to the sub-contractors. DHS Contract	How do you provide internal quality assurance to monitor your sub-contractors performance at least annually and what is your process of providing the sub-contractors with that and other pertinent information?
12. The Local Authority annually contracts with the division to provide substance abuse & mental health programs and services. 17-43-201(4)(h) / 17-43-301(4)(a)(viii)	Is this necessary for the interview? Could review Board Minutes and contract.
13. The Local Authority appoints directly or by contract a part time or full time director for substance abuse and mental health programs and prescribes the director's duties. 17-43-201(4)(d) / 17-43-301(4)(a)(iv)	Please describe your involvement in the selection of your Director(s). How do you select your Director(s) and determine the duties of the Director(s)?

LA Responsibilities	Comments:
14. The Local Authority provides input and comment on new and revised policies established by the DSAMH board. <i>17-43-201(4)(e) / 17-43-301(4)(a)(v)</i>	What is your involvement in providing comment on new and revised policies established by the DSAMH Board? What is the customary process?
15. The Local Authority established mechanisms allowing for direct citizen input. <i>17-43-201(4)(g) / 17-43-301(4)(a)(vii)</i>	How do you provide for direct citizen input?
16. The Local Authority complies with all applicable state and federal statutes, policies, audit requirements, contract requirements, and any directives resulting from those audits and contract requirements. <i>17-43-201(4)(i) / 17-43-301(4)(a)(xi)</i>	Is this necessary for the interview? Could review Board Minutes, Bylaws and Policies.
17. The Local Authority charges a fee for substance abuse and mental health services – exception: inability to pay circumstances. <i>17-43-204(1) / 62A-15-713(7)</i>	What is your process of determining client fee schedule for SA/MH services provided? Please describe your policy regarding inability to pay circumstances and individuals who are indigent and meet the criteria for serious and persistent mental illness or severe emotional disturbance.
18. The Local Authority pays for the cost of services for persons residing in their jurisdiction. <i>17-43-204(3) / 17-43-306(2)</i>	How do you ensure the provision of services mandated by state code?
19. The Local Authority or its contract provider shall invite and include all funding partners in its auditor's pre and exit conferences. <i>62A-15-110(1)(c) / 62A-15-713(3)</i>	How do you intend to ensure the invitation and inclusion of all funding partners in the auditor's pre and exit conferences?
20. Each member of the Local Authority shall annually certify that he has received and reviewed the independent audit and has participated in a formal interview with the provider's executive officers <i>62A-15-110(1)(d) / 62A-15-713(4)</i>	Is this necessary? Already covered in Number 10. Could also review Board Minutes.
21. The Local Authority ensures that requested information and outcome data is provided to the DSAMH in the manner and within the timelines defined by DSAMH. <i>62A-15-110(1)(e) / 62A-15-713(5)</i>	Provide outcome data summary for the year and ask if the Locals are aware of any problems if they exist.
22. All audit reports by state or county persons or entities concerning the local authority or its contract provider was provided to the executive director of DHS, the Local Authority, and members of the contract provider's governing board. <i>62A-15-119(1)(f) / 62A-15-713(6)</i>	Is this necessary for the interview? Could check Board Minutes and with DSAMH then present information if needed.
23. How can DSAMH improve on the Governance and Oversight review and audit process?	
24. Please provide suggestions for improved Local Authority Oversight, requirements, etc.	Are there methods you might, or have been implemented to improve your oversight responsibilities?
25. Local Authority strengths and barriers to providing sufficient oversight of programs/services and proper use of public funds.	What do you perceive as your strength and barriers to providing sufficient oversight of program services and the proper use of funding?

CONTRACT MONITOR

(Signature)

Date

**\*LAST YEAR'S ANNUAL REVIEW FOLLOW UP**

Contractor Name: \_\_\_\_\_

Contract Number #: \_\_\_\_\_ Date \_\_\_\_\_

**Ratings: P = pass F = fail NA = not applicable**

Monitoring Issue/Area Fill in areas of concern from last year's review.	Rating (Pass / Fail / NA)			Comments:
	P	F	NA	
	P	F	NA	
	P	F	NA	
	P	F	NA	
	P	F	NA	
	P	F	NA	
	P	F	NA	
	P	F	NA	
	P	F	NA	

\_\_\_\_\_  
CONTRACT MONITOR (Signature)\_\_\_\_\_  
Date

\*Pre Review Form to Complete

## CHECK EXPENDITURES REVIEW TOOL

**LSAA/LMHA Center:**

**Date of Review:**

Type of Review: Executive\_\_\_\_\_ Check Register\_\_\_\_\_

[illegible]





# PERSONNEL FILES

**LSAA/LMHA Center:** \_\_\_\_\_

Date of Review: \_\_\_\_\_

[illegible]

## BOARD MINUTES REVIEW

[illegible]

# **Appendix 7:**

## **Corrective Action**

(This section is on the State Web Site)  
[http://www.hsofo.utah.gov/qa\\_forms.htm](http://www.hsofo.utah.gov/qa_forms.htm)

# **Appendix 8:**

## **Data Submission Requirements**

# **Mental Health**

## **Data Submission Requirements**

**March 2005**



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## Mental Health Data Reporting Deadlines<sup>1</sup>

All information system<sup>2</sup> and outcomes system data<sup>3</sup> are to be submitted electronically<sup>4</sup> according to the following schedule:

Reporting Period	Deadline
Quarter 1 (July 1-September 30)	November 15
Quarter 2 (October 1-December 31)	February 15
Quarter 3 (January 31-March 31)	May 15
Quarter 4 (April 1-June 30)	August 15

---

<sup>1</sup> Penalties for non-compliance are shown in the contract.

<sup>2</sup> Information system data are the client and event data sets.

<sup>3</sup> Outcomes system data are:

Adults:           GWBPLUS  
                    General Well Being (GWB)  
                    Brief Substance Abuse Scale (BSAS)  
                    MHSIP Consumer Survey  
Children/Youth: Y-OQ<sup>R</sup>-30.1  
                    Parents  
                    Youth  
                    Youth Services Survey (MHSIP)  
                    Parents - YSS-F  
                    Youth - YSS

<sup>4</sup> Electronic submissions may be made by email, mailed diskettes, or Web-based entry (when available). Security measures should be used to ensure that data is kept confidential during transport.



## Adult Outcomes and Consumer Satisfaction

The Consumer Self Assessment instrument is referred to as the GWBPLUS, which consists of two instruments and covers the domains of 1) measured symptom change (GWB), and 2) measured substance abuse change (BSAS).

### GENERAL WELL-BEING SCHEDULE/POSITIVE MENTAL HEALTH INDEX (GWB)

#### *Instrument Description and Characteristics*

The GWB/PMHI, hereafter simply referred to as the GWB, focuses on symptoms and functioning. Harold Dupuy, as part of a nationwide survey of health, developed it in the 1970s. During the succeeding years it has been further developed and refined. It has had use in a large number of studies dealing with mental health need assessment and treatment outcomes.

In Utah, the GWB/PMHI has been used in statewide substance abuse need assessment studies to assist in identifying psychological distress and dysfunction and in both center and statewide mental health outcome studies. This will permit comparisons over time, between geographical sites, and between various types of community-based samples. In addition, use of this instrument will permit comparisons with previous statewide outcome studies completed in Utah.

The GWB is a 22-item instrument with items addressing the following areas: sense of general well-being, energy level, emotional/behavioral control, depressed/cheerful mood, tension/anxiety state, and somatic distress or health worries. High scores indicate positive adjustment and low scores reflect perceived problems or psychological impairment.

This instrument is appropriate for use with adults and older adolescents and is applicable to most adult clinical and diagnostic groups. It covers the full range of functional adjustment from normal to severe impairment. It is less appropriate for populations whose psychopathology prevents them from responding to self report instruments or who may be experiencing severe reality distortion or gross mental disorganization.

**Reliability.** Good to excellent reliability figures have been reported. Internal consistency figures range between .87 - .95, test-retest figures over a three-month interval range between .69 - .85.

**Validity.** The instrument has been shown to clearly discriminate between mental health clients and normal populations samples. It is highly correlated with mental health professionals' judgments of depression and has substantial correlations (.30 - .53) with 'real world' events, such as reported nervous breakdowns, consultations with mental health professionals, the perceived need for psychological help, and experiencing of "severe" psychological problems and similar indicators of impairment in adjustment. The GWB also has substantial correlations (.49 - .81) with other well-known and widely recognized measures of psychopathology, such as the MMPI, the Beck Depression scales and the Psychiatric Symptom Scale.

**Sensitivity to Change.** Sensitivity to change is good. Numerous studies involving inpatient, outpatient, and day treatment populations have shown significant positive changes as a function of treatment.

*A sub-scale of the GWB, the Positive Mental Health Index (PMHI) has been selected for use in the Outcome System. The PMHI is composed of 10 items, each of which has six response categories. The PMHI correlates very highly with the total GWB score and with other instruments frequently used in outcome studies. PMHI scores range from 0-50. This instrument consists of the first 10 questions of the Consumer Self Assessment at both Times 1 and 2.*

### ***Sampling and Data Collection Procedures***

**Admission.** All adults being admitted or readmitted to mental health services at each center are to complete the PMHI shortly before or at the time services are initiated. For the purposes of this project, the adult sample includes individuals 18 years or older at the time of admission. This includes all adults regardless of the type of program or modality of service to which admitted. The PMHI is to be administered to admissions to outpatient, inpatient, residential, day treatment, medication management, or other program of each provider. It is not to be administered when there is a change in program or modality. For example, if a client completed the PMHI at the time of admission to a residential program, and is subsequently transferred to an outpatient program at the same center, it would not be administered again at the outpatient unit. Since the instrument is quickly and easily completed (administration takes approximately 10 minutes), it is felt that there will be little or no conflict with existing intake procedures. The proposed client should complete the instrument before initial screening interviews or other assessment procedures. The PMHI should be included in and adopted as part of the standard intake protocol for each provider. It should be completed as one of other standard documents, such as the financial statement or consent to treatment, which are routinely completed or responded to by all clients.

If for some reason the PMHI is not completed at or prior to the first clinical visit, it is to be completed no later than the second visit or within three weeks of admission. In all cases, it is necessary to include the date of administration in order to make comparisons to the date of admission for the individual in question.

**Follow-up.** Each provider is to develop tracking procedures, which will identify each client that has been in service for 90 days. At this time, the PMHI is to be administered a second time, preferably at a program site (i.e., outpatient clinic, residential program, day treatment, or clubhouse program, etc. If the client has discontinued services or has been discharged from services in less than 90 days, the second administration is to be done in the most effective and efficient way possible. It is expected that many cases will need to be contacted by mail. This may require multiple mailings and follow-up with phone calls. Each provider is to monitor its follow-up completions to maximize the response rate. A target response rate of 50 % or higher is most desirable.

### *Scoring and Data Analysis*

Each provider will be responsible for scoring and clinical use of the instrument and maintaining copies of the data files provided and the details on how the value for each variable or data point for each client was obtained. In addition, each provider is expected to provide client-by-client responses to each item. This information is to be included in an ASCII data file.

### *Technical Reporting of Results*

The Division will coordinate statewide reporting of the data. It is anticipated that a number of analyses will be completed. These will focus on percent of clients with various characteristics which demonstrate improvement, the amount of improvement demonstrated, how this improvement as measured by the PMHI correlates with the amount of services provided, with provider characteristics, satisfaction with treatment and other hygienic variables associated with services. For example, is satisfaction with fees, appearance, or accessibility of the mental health provider associated with outcomes? Does the age, sex, or diagnoses of the client affect the degree of improvement? What factors best predict outcomes for various types of clients? How does impairment at admission affect the amount of improvement?

Analyses will focus on the interaction of all the variables that are collected and associated with an episode of treatment for a given client. The relationship between client characteristic, level of satisfaction, hygienic factors associated with the delivery of services, and outcome as measured by a comparison between the admission and follow-up PMHI scores will be analyzed on a statewide basis. Providers using the data and information pertaining to their own sample of clients may perform similar analyses.

### BRIEF SUBSTANCE ABUSE SCALE (BSAS)

This five-item instrument was developed to briefly assess to what extent alcohol and/or drugs is self-perceived by the client to be a problem at the time of admission to community mental health centers. The instrument consists of items 11-15 in the Consumer Self Assessment questionnaire. Psychometric data on reliability, validity, and sensitivity to change are not yet available. Data are collected at time one and time two. Data collection procedures are the same as for the GWB.

### MHSIP CONSUMER SURVEY

This instrument consists of 28 questions, including three items from the previous consumer satisfaction instrument. The core 25 questions are taken from the Mental Health Statistics Improvement Program (MHSIP) short survey form. The instrument domains are consumer perceptions of treatment outcome or effectiveness, access, quality/appropriateness, participation in treatment decisions, and general satisfaction. As part of an on going process to test questions that measure the new SAMHSA outcome measures Utah, along with other states, has agreed to include additional items in our MHSIP from time to time to test for their effectiveness. The MHSIP will no longer be administered as part of the Consumer Self Assessment T-2, but will be administered as a point-in-time covering a consecutive 2 to 4 weeks each fiscal year. The DSAMH will provide the forms, or it can be filled out online. All adults receiving services during that set time period will be asked to complete the survey. The forms will be returned to DSAMH for analysis.

Mental Health Data Submission Requirements  
March 2005

STANDARD HEADER FILE FOR ALL OUTCOME/CONSUMER SATISFACTION SUBMISSIONS								
Submission must be in comma-delimited format. All header information should appear as the first record of the submission file. The data file begins as record 2. For example, on the first line the header information might appear as follows: 11,2,13,1 (SJ, Time 2, YSS-Family, raw data)								
Field	Field Name	Description	Codes/Allowed Values	Field Length	Format	Required	Example	Notes
1	CenterID	Center ID number	1= Bear River–BR 2= Weber–WB 3= Davis–DV 4= Valley–VL 6= Wasatch–WS 7= Central–CU 8= Southwest–SW 9= NortheasternNE 10= Four Corners–FC 11= San Juan–SJ 12= State Hospital	2	n	Yes	8	
2	Filecode	Signifies Time 1 or Time 2	1=Time 1 data 2=Time 2 data	1	n	Yes	1	
3	Formcode	Code to identify instrument being submitted	1=GWBPLUS 8=Y-OQ <sup>R</sup> -30.1 Parent) 9=Y-OQ <sup>R</sup> -30.1 Youth 13=YSS-F Parent 14=YSS Youth	2	N	Yes	13	
4	DataType	Type of data submitted	1= Raw data 2= All data scored and recoded	1	N	Yes	1	If data are recoded <b><u>all</u></b> data must be recoded

<b>UTAH PUBLIC MENTAL HEALTH OUTCOME SYSTEM</b>								
<b><u>GWBPLUS TIME 1 SUBMISSION FORMAT</u></b>								
(Data submission begins as record number 2 of the submission file following the header information)								
<b>Field#</b>	<b>Field Name</b>	<b>Description</b>	<b>Codes/Allowed Values</b>	<b>Field Length</b>	<b>Format</b>	<b>Required</b>	<b>Example</b>	<b>Notes</b>
1	RecordNo	Sequential Record Number	1, 2, . . . N Records	10	N . . . n	Yes	1	Each record must have a sequential number beginning with 1.
2	Clientid	ID for Client		15	Text, string or alpha-numeric	Yes	056822	ID number must be consistent across file submissions
3	Datet1	Date of Time 1 administration	Legal Date	10	mm/dd/yyyy	Yes	10/23/2000	Use four digits for year
4	GWB1	Item 1	1-6	1	n	Yes	1	
5	GWB2	Item 2	1-6	1	n	Yes	1	
6	GWB3	Item 3	1-6	1	n	Yes	1	
7	GWB4	Item 4	1-6	1	n	Yes	1	
8	GWB5	Item 5	1-6	1	n	Yes	1	
9	GWB6	Item 6	1-6	1	n	Yes	1	
10	GWB7	Item 7	1-6	1	n	Yes	1	
11	GWB8	Item 8	1-6	1	n	Yes	1	
12	GWB9	Item 9	1-6	1	n	Yes	1	
13	GWB10	Item 10	1-6	1	n	Yes	1	
14	SAGWB11	Item 11	1-7	1	n	Yes	7	
15	SAGWB12	Item 12	1-6	1	n	Yes	6	
16	SAGWB13	Item 13	1-8	1	n	Yes	8	
17	SAGWB14	Item 14	1-9	1	n	Yes	9	
18	SAGWB15	Item 15	1-7	1	n	Yes	7	
19	GWB16	Item 16	1-6	1	n	Yes	1	Access question



<b>UTAH PUBLIC MENTAL HEALTH OUTCOME SYSTEM</b>								
<b><u>GWBPLUS TIME 2 SUBMISSION FORMAT</u></b>								
(Data submission begins as record number 2 of the submission file following the header information)								
<b>Field#</b>	<b>Field Name</b>	<b>Description</b>	<b>Codes/Allowed Values</b>	<b>Field Length</b>	<b>Format</b>	<b>Required</b>	<b>Example</b>	<b>Notes</b>
1	RecordNo	Sequential Record Number	1, 2, . . . N Records	10	N . . . n	Yes	1	Each record must have a sequential number beginning with 1.
2	ClientID	ID for Client	Varies by Center	15	Text, string or alpha-numeric	Yes	056822	ID number must be consistent across file submissions
3	Datet2	Date of Time 2 administration	Legal Date	10	mm/dd/yyyy	Yes	10/23/2000	Use four digits for year
4	GWB1	Item 1	1-6	1	n	Yes	1	
5	GWB2	Item 2	1-6	1	n	Yes	1	
6	GWB3	Item 3	1-6	1	n	Yes	1	
7	GWB4	Item 4	1-6	1	n	Yes	1	
8	GWB5	Item 5	1-6	1	n	Yes	1	
9	GWB6	Item 6	1-6	1	n	Yes	1	
10	GWB7	Item 7	1-6	1	n	Yes	1	
11	GWB8	Item 8	1-6	1	n	Yes	1	
12	GWB9	Item 9	1-6	1	n	Yes	1	
13	GWB10	Item 10	1-6	1	n	Yes	1	
14	SAGWB11	Item 11	1-7	1	n	Yes	7	
15	SAGWB12	Item 12	1-6	1	n	Yes	1	
16	SAGWB13	Item 13	1-8	1	n	Yes	8	
17	SAGWB14	Item 14	1-9	1	n	Yes	9	
18	SAGWB15	Item 15	1-7	1	n	Yes	7	

## Consumer Self Assessment: T-1

Name: \_\_\_\_\_ Date : \_\_\_\_\_

Sex: Male Female Age: \_\_\_\_\_ ID: \_\_\_\_\_ Unit: \_\_\_\_\_

For each question below, please select the option that most closely matches your own feelings or situation. Indicate your selection by darkening the small circle next to the best alternative.

1. How have you been feeling during the past week or two?

1 O - In excellent spirits  
2 O - In very good spirits  
3 O - In good spirits mostly  
4 O - I have been up and down in spirits a lot  
5 O - In low spirits mostly  
6 O - In very low spirits

2. Have you been bothered by nervousness or your "nerves" during the past week or two?

1 O - Extremely so - to the point where I could not work or take care of things  
2 O - Very much so  
3 O - Quite a bit  
4 O - Some - enough to bother me  
5 O - A little  
6 O - Not at all

3. Have you been in firm control of your behavior, thoughts, emotions, or feelings during the past week or two?

1 O - Yes, definitely so  
2 O - Yes, for the most part  
3 O - Generally so  
4 O - Not too well  
5 O - No, and I am somewhat disturbed  
6 O - No, and I am very disturbed

4. Have you felt so sad, discouraged, hopeless or had so many problems that you wondered if anything was worthwhile during the past week or two?

1 O - Extremely so - to the point that I have just about given up  
2 O - Very much so  
3 O - Quite a bit  
4 O - Some - enough to bother me  
5 O - A little bit  
6 O - not at all

5. How happy, satisfied, or pleased have you been with your personal life during the past week or two?

1 O - Extremely happy - could not have been more satisfied or pleased  
2 O - Very happy  
3 O - Fairly happy  
4 O - Satisfied, pleased  
5 O - Somewhat dissatisfied  
6 O - Very dissatisfied

6. Have you been under or felt you were under any strain, stress, or pressure during the past week or two?

1 O - Yes, almost more than I could bear or stand  
2 O - Yes, quite a bit of pressure  
3 O - Yes, some - more than usual  
4 O - Yes, some - but about usual  
5 O - Yes, a little  
6 O - Not at all

7. Have you had any reason to wonder if you were losing control over the way you talk, think or feel during the past week or two?

1 O - Not at all  
2 O - Only a little  
3 O - Some, but not enough to be concerned or worried about  
4 O - Some, and I have been a little concerned  
5 O - Some, and I am quite concerned  
6 O - Yes, very much so and I am very concerned

8. Have you been anxious, worried or upset during the past week or two?

1 O - Extremely so, to the point of being sick, or almost sick  
2 O - Very much so  
3 O - Quite a bit  
4 O - Some, enough to bother me  
5 O - A little bit  
6 O - Not at all

9. Have you felt down-hearted and blue during the past week or two?

- 1 O - All the time
- 2 O - Most of the time
- 3 O - A good bit of the time
- 4 O - Some of the time
- 5 O - A little of the time
- 6 O - None of the time

10. Have you been feeling emotionally stable and sure of yourself during the past week or two?

- 1 O - All the time
- 2 O - Most of the time
- 3 O - A good bit of the time
- 4 O - Some of the time
- 5 O - A little of the time
- 6 O - None of the time

11. How often have you used alcohol during the past 30 days or so?

- 1 O - Several times (4 or more ) a week
- 2 O - Two or three times a week
- 3 O - About once a week
- 4 O - Only once or twice a month
- 5 O - Have not used in the last 30 days
- 6 O - Used, but more than 30 days ago
- 7 O - I have never used alcohol

12. How often have you used street or unprescribed drugs during the past 30 days or so?

- 1 O - Several times (4 or more ) a week
- 2 O - Two or three times a week
- 3 O - About once a week
- 4 O - Only once or twice a month
- 5 O - Have not used in the last 30 days
- 6 O - Used, but more than 30 days ago
- 7 O - I have never used alcohol

13. How much difficulty have you had in controlling your use of alcohol or other drugs during the last 30 days?

- 1 O - Quite a bit of difficulty - it has been pretty hard sometimes
- 2 O - A fair amount of difficulty - it has been a challenge
- 3 O - Some difficulty, but I have managed fairly well
- 4 O - very little difficulty
- 5 O - None at all - it has been easy
- 6 O - I have never used any alcohol or drugs

14. Do you agree or disagree with the following statement:

“A lot of my problems are because of using alcohol or other drugs.”

- 1 O - Agree entirely
- 2 O - Mostly agree
- 3 O - Agree a little
- 4 O - Neither agree nor disagree
- 5 O - Disagree a little
- 6 O - Mostly disagree
- 7 O - Disagree entirely
- 8 O - I have never used alcohol or other drugs

15. How much of a problem is your use of alcohol or other drugs? - Would you say:

- 1 O - It's a really serious problem
- 2 O - It a major problem for me
- 3 O - It's a pretty big problem for me
- 4 O - It's more trouble than it's worth
- 5 O - It's causing me some difficulties
- 6 O - It's a bit of a problem
- 7 O - It has been a problem in the past, but is not a problem now
- 8 O - It has never been a problem
- 9 O - I have never used alcohol or other drugs

For question 16 please indicate how much you agree or disagree with the statement based on your experience at our mental health center:

		Agree			Neutral	Disagree		
	Strongly	Mostly	Some			Some	Mostly	Strongly
16. I am satisfied with the amount of time it took from first contact for mental health services until my first appointment.	0	0	0	0	0	0	0	0
	7	6	5	4	3	2	1	

## Consumer Self Assessment: T-2-- Part I

Name : \_\_\_\_\_ Date : \_\_\_\_\_

Sex: Male Female Age: \_\_\_\_\_ ID: \_\_\_\_\_ Unit: \_\_\_\_\_

For each question below, please select the answer which most closely matches your own feelings or situation. Indicate your selection by darkening the small circle next to the best choice for you.

1. How have you been feeling during the past week or two?
  - 1 O - In excellent spirits
  - 2 O - In very good spirits
  - 3 O - In good spirits mostly
  - 4 O - I have been up and down in spirits a lot
  - 5 O - In low spirits mostly
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2. Have you been bothered by nervousness or your "nerves" during the past week or two?
  - 1 O - Extremely so - to the point where I could not work or take care of things
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  - 4 O - Some - enough to bother me
  - 5 O - A little
  - 6 O - Not at all
3. Have you been in firm control of your behavior, thoughts, emotions, or feelings during the past week or two?
  - 1 O - Yes, definitely so
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  - 3 O - Generally so
  - 4 O - Not too well
  - 5 O - No, and I am somewhat disturbed
  - 6 O - No, and I am very disturbed
4. Have you felt so sad, discouraged, hopeless or had so many problems that you wondered if anything was worthwhile during the past week or two?
  - 1 O - Extremely so - to the point that I have just about given up
  - 2 O - Very much so
  - 3 O - Quite a bit
  - 4 O - Some - enough to bother me
  - 5 O - A little bit
  - 6 O - not at all
5. How happy, satisfied, or pleased have you been with your personal life during the past week or two?
  - 1 O - Extremely happy - could not have been more satisfied or pleased
  - 2 O - Very happy
  - 3 O - Fairly happy
  - 4 O - Satisfied, pleased
  - 5 O - Somewhat dissatisfied
  - 6 O - Very dissatisfied
6. Have you been under or felt you were under any strain, stress, or pressure during the past week or two?
  - 1 O - Yes, almost more than I could bear or stand
  - 2 O - Yes, quite a bit of pressure
  - 3 O - Yes, some - more than usual
  - 4 O - Yes, some - but about usual
  - 5 O - Yes, a little
  - 6 O - Not at all
7. Have you had any reason to wonder if you were losing control over the way you talk, think or feel during the past week or two?
  - 1 O - Not at all
  - 2 O - Only a little
  - 3 O - Some, but not enough to be concerned or worried about
  - 4 O - Some, and I have been a little concerned
  - 5 O - Some, and I am quite concerned
  - 6 O - Yes, very much so and I am very concerned
8. Have you been anxious, worried or upset during the past week or two?
  - 1 O - Extremely so, to the point of being sick, or almost sick
  - 2 O - Very much so
  - 3 O - Quite a bit
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  - 5 O - A little bit
  - 6 O - Not at all

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- 7 O - I have never used alcohol

12. How often have you used "street" or "unprescribed" drugs during the past 30 days or so?

- 1 O - Several times (4 or more ) a week
- 2 O - Two or three times a week
- 3 O - About once a week
- 4 O - Only once or twice a month
- 5 O - Have not used in the last 30 days
- 6 O - Used, but more than 30 days ago
- 7 O - I have never used alcohol

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- 4 O - Very little difficulty
- 5 O - None at all - it has been easy
- 6 O - I have never used any alcohol or drugs

14. Do you agree or disagree with the following statement:

"A lot of my problems are because of using alcohol or other drugs."

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- 2 O - It a major problem for me
- 3 O - It's a pretty big problem for me
- 4 O - It's more trouble than it's worth
- 5 O - It's causing me some difficulties
- 6 O - It's a bit of a problem
- 7 O - It has been a problem in the past, but is not a problem now
- 8 O - It has never been a problem
- 9 O - I have never used alcohol or other drugs

## MHSIP Consumer Survey

In order to provide the best possible services, we need to know what you think about the services you received during the past 12 months, the people who provided the services, and the results. Please choose the answer that best fits your feelings and fill in the corresponding circle, fill out only one survey per month. Your answers will be kept confidential.

<b>Local Authority:</b>  <input type="radio"/> Bear River Health Department <input type="radio"/> Bear River Mental Health <input type="radio"/> Central Utah MH/Substance Abuse <input type="radio"/> Davis Behavioral Health <input type="radio"/> Four Corners Community Behavioral Health, Inc. <input type="radio"/> Heber Valley Counseling <input type="radio"/> Northeastern Counseling <input type="radio"/> Salt Lake County Substance Abuse <input type="radio"/> San Juan Counseling <input type="radio"/> Southwest Center <input type="radio"/> Utah County Division of Substance Abuse <input type="radio"/> Valley Mental Health <input type="radio"/> Wasatch Mental Health <input type="radio"/> Weber County Substance Abuse <input type="radio"/> Other (specify): _____ 	<b>Date of Birth:</b>  <div style="text-align: center; margin-bottom: 10px;">             ____/____/____              M M D D Y Y Y Y           </div> <table style="width: 100%; text-align: center;"> <tr><td style="width: 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<b>Gender</b>  <input type="radio"/> Male <input type="radio"/> Female
<b>Race</b>  <input type="radio"/> Alaska Native <input type="radio"/> American Indian <input type="radio"/> Asian <input type="radio"/> Native Hawaiian/Other Pacific Islander <input type="radio"/> Black or African American <input type="radio"/> White <input type="radio"/> Other Single Race <input type="radio"/> Two or More Races

Ethnicity	
White	65.0
Black	12.0
Asian	10.0
Hispanic	8.0
Other	5.0

- |   |
|---|
| <input type="radio"/> Puerto Rican<br><input type="radio"/> Mexican<br><input type="radio"/> Cuban<br><input type="radio"/> Other Specific Hispanic<br><input type="radio"/> Not of Hispanic Origin<br><input type="radio"/> Hispanic – Specific Origin Not Specified |
|---|

**When did you start getting services at this center for you current problems?**

- ☐ 3 months ago or less
- ☐ 4-6 months ago
- ☐ 7-9 months ago
- ☐ 10-12 months ago
- ☐ one year or more

Please indicate your agreement/disagreement with each of the following statements by selecting the option that best represents your opinion. If the question is about something you have not experienced, select the “not applicable” option.

		Strongly Disagree	Disagree	I am neutral	Agree	Strongly Agree	Not Applicable
1.	I like the services that I received here.	0	0	0	0	0	0
2.	If I had other choices, I would still get services from this agency.	0	0	0	0	0	0
3.	I would recommend this agency to a friend or family member.	0	0	0	0	0	0
4.	The location of services was convenient (parking, public transportation, distance, etc.).	0	0	0	0	0	0
5.	Staff were willing to see me as often as I felt it was necessary.	0	0	0	0	0	0
6.	Staff returned my calls in 24 hours.	0	0	0	0	0	0
7.	Services were available at times that were good for me.	0	0	0	0	0	0
8.	I was able to get all the services I thought I needed.	0	0	0	0	0	0
9.	I was able to see a psychiatrist, clinician or therapist when I wanted to.	0	0	0	0	0	0
10.	Staff here believe that I can grow, change and recover.	0	0	0	0	0	0
11.	I felt comfortable asking questions about my treatment and/or medication.	0	0	0	0	0	0
12.	I felt free to complain.	0	0	0	0	0	0
13.	I was given information about my rights.	0	0	0	0	0	0

		Strongly Disagree	Disagree	I am neutral	Agree	Strongly Agree	Not Applicable
14.	Staff encouraged me to take responsibility for how I live my life.	O	O	O	O	O	O
15.	Staff told me what side effects to watch out for.	O	O	O	O	O	O
16.	Staff respected my wishes about who is and who is not to be given information about my treatment.	O	O	O	O	O	O
17.	I, not staff, decided my treatment goals.	O	O	O	O	O	O
18.	Staff were sensitive to my cultural background (race, religion, language, etc.).	O	O	O	O	O	O
19.	Staff helped me obtain the information I needed so that I could take charge of managing my illness.	O	O	O	O	O	O
20.	I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	O	O	O	O	O	O

**As a Direct Result of Services I Received:**

21.	I deal more effectively with daily problems.	O	O	O	O	O	O
22.	I am better able to control my life.	O	O	O	O	O	O
23.	I am better able to deal with crisis.	O	O	O	O	O	O
24.	I am getting along better with my family.	O	O	O	O	O	O
25.	I do better in social situations.	O	O	O	O	O	O
26.	I do better in school and/or work.	O	O	O	O	O	O
27.	My housing situation has improved.	O	O	O	O	O	O
28.	My symptoms are not bothering me as much.	O	O	O	O	O	O

Please feel free to use this space to comment on any of your answers. Also, if there are areas which were not covered by this questionnaire which you feel should have been, please enter them here.

**ADDITIONAL COMMENTS:**



Are you receiving services in San Juan County or Wasatch County?

- ☐ Yes (**if yes stop here**)
- ☐ No (**continue to next question**)

Have you had Medicaid at any time while you were getting services?

- ☐ Yes (**continue to next question**)
- ☐ No (**if no stop here**)

Are you receiving Mental Health services from this agency?

- ☐ Yes (**continue to next questions**)
- ☐ No (**if no stop here**)

		Yes, and I understand	Yes, but I don't understand	No	Don't know	Can't remember
1.	The Medicaid Handbook was explained to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.	The Client Rights Statement was explained to me.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	I was told how to get emergency services if I needed them.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.	I was told how to get transportation services if I needed them.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.	I was told how to file an appeal or a grievance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.	I was told I could have a choice of therapists.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## **Child/Youth Outcomes and Consumer Satisfaction**

METHODS: YOUTH LIFE STATUS QUESTIONNAIRE (Y-OQ<sup>R</sup>-30.1) 9-26-2002

### **Introduction**

The Y-OQ<sup>R</sup>-30.1 is valid and reliable. It is designed to detect treatment change (sensitivity) or outcomes regardless of treatment modality, diagnosis, or discipline of the treating professional. The measure functions well as a screening tool.

The Y-OQ<sup>R</sup>-30.1, known as the OMNI Version, was piloted and developed for use by both adult and youth raters. For example, parents would replace the first person referent “I” with “My child” at the beginning of each sentence. The measure consists of 30 closed-ended questions, including critical items that may be used by clinicians for treatment planning and other clinical uses. One of these critical items pertains to suicidal thoughts, and another relates to alcohol or drug use.

Each statement has a five-point rating scale as follows: 0 - Never or Almost Never, 1- Rarely, 2 - Sometimes, 3 - Frequently, 4 - Almost Always or Always. Total scores may range from 0 to 120.

### *Data Collection Procedures*

- Who is to be rated?
  - All child admissions 0-17 years of age.
- Who is to do the ratings?
  - All youth 12-17 years of age.
  - One parent/guardian for each youth 12-17 or child 0-11 years of age. If a parent or guardian is not available, ratings may be made by another adult who is sufficiently familiar with the youth or child.
- What organizations are to administer the measures?
  - All CMHCs and the State Hospital.
- When are the measures to be administered?
  - Near the time of admission or intake.
  - Between 45-60 days after intake.
  - About six months after intake.
  - Every six months thereafter for continuing clients.

- How are the measures to be administered?
  - Utah State Hospital
    - All time one and time two or later administrations at the Utah State Hospital will be conducted only with youth, and then only while youth are in the hospital.
  - Time One (CMHCs)
    - Time ones would almost always be collected in the clinic or in a day treatment or 24-hour setting. CMHCs must report the location where the instrument was administered.
  - Time Two and Later (CMHCs)
    - These measures would be collected by mail, in the clinic or in a day treatment or 24-hour setting. CMHCs must report the location where the instrument was administered.
- How should the mail-out methodology be implemented?
  - The CMHC director should sign letters.
  - Parents and youth should receive letters in separate envelopes and should be encouraged to complete the instrument independently.
  - A reminder letter and questionnaire should be sent two weeks following the first mailing. Letters should be sent to individuals by name to make the letters more personal and to enhance response rate.
  - Each provider is to monitor its follow-up completions to maximize the response rate. Response rates of 30% or higher are sought. Centers are encouraged to do additional mailings and follow-up phone calls to enhance their response rate.

### *Scoring, Data Analysis, and Reporting*

Each provider is responsible for data collection, input, scoring, and clinical use of the instrument. Information should be entered in an ASCII data file and provided to the Division for statewide analysis and reporting. Results will be reported semi-annually, but not more frequently because of small numbers. Providers will be informed quarterly whether data submissions have been received. Comparisons will be made using the following classifications: provider organization, SED/Non-SED, Medicaid/Non-Medicaid, gender, age group, and by rater (parent/youth). In addition, data will be made available on the Department of Human Services (DHS) Data Warehouse so Centers and UBHN can perform further data analysis.

### Electronic File Submissions

Attached are copies of the standardized file formats for all submissions. As with previous submissions, formats should be followed exactly as requested to enhance accuracy and data analysis efficiency.

UTAH PUBLIC MENTAL HEALTH OUTCOME SYSTEM								Page 1 of 1
Y-OQ <sup>R</sup> -30-1 Time 1 (Data submission begins as record number 2 of the submission file following the header information)								
Field#	Field Name	Description	Codes/Allowed Values	Field Length	Format	Required	Example	Notes
1	RecordNo	Sequential Record Number	1, 2, . . .N Records	10	n...n	Yes	1	Each record must have a sequential number beginning with 1.
2	ClientID	ID for Client	Varies by Center	15	Text, string or alpha-numeric	Yes	056822	ID number must be consistent across file submissions
3	Datet1	Date of Time 1 administration	Legal Date	10	mm/dd/yyyy	Yes	01/03/2003	Use four digits for year
4	YOQScore	Total Score ranging from 0-120	0-120	3	n...n	Yes	78	Sum items to obtain total score. Do not report leading zeroes. Keep instrument in chart for clinical use.
5	Rater	Person doing the rating	1 Adolescent 2 Parent/guardian 3 Foster Parent 4 Clinician 5 Other	1	n	Yes	2	A parent/guardian or other rates children under 12 years of age
6	Administration	Form completion	1 In-clinic 2 Day treatment or 24-hour setting 3 Mail-out	1	n	Yes	1	Rarely would a Time 1 administration be returned by mail

UTAH PUBLIC MENTAL HEALTH OUTCOME SYSTEM								Page 1 of 1
Y-OQ <sup>R</sup> -30-1 Time 2 or later (Data submission begins as record number 2 of the submission file following the header information)								
Field#	Field Name	Description	Codes/Allowed Values	Field Length	Format	Required	Example	Notes
1	RecordNo	Sequential Record Number	1, 2, . . .N Records	10	n...n	Yes	1	Each record must have a sequential number beginning with 1.
2	ClientID	ID for Client	Varies by Center	15	Text, string or alpha-numeric	Yes	056822	ID number must be consistent across file submissions
3	Datet1	Date of Time 2 or later administration	Legal Date	10	mm/dd/yyyy	Yes	07/03/2003	Use four digits for year
4	YOQScore	Total Score ranging from 0-120	0-120	3	n...n	Yes	78	Sum items to obtain total score. Do not report leading zeroes. Keep instrument in chart for clinical use.
5	Rater	Person doing the rating	1 Adolescent 2 Parent/guardian 3 Foster Parent 4 Clinician 5 Other	1	n	Yes	2	A parent/guardian or other rates children under 12 years of age
6	Administration	Form completion	1 In-clinic 2 Day treatment or 24-hour setting 3 Mail-out	1	n	Yes	1	Time 2 is completed between 45-60 days following intake; 6-mo. administrations are completed every 6 mos. following intake.

## METHODS: PARENT AND YOUTH SERVICES SURVEYS

### *Introduction*

There are two parallel versions of the instrument, one for parents or caregivers (YSS-F) and one for youth (YSS). The YSS-F consists of 26 closed-ended questions and the YSS consists of 25 closed-ended questions. Each instrument also has three open-ended questions. The closed-ended questions contain a five-point rating scale: strongly disagree, disagree, undecided, agree, and strongly agree. The open-ended questions are included to find out what consumers liked most and least about services, and how they think services could be improved. Additional questions may be added as rested by SAMHSA.

Instrument domains are general satisfaction, perceived outcomes, quality/appropriateness, and access. These instruments are an adaptation by Molly Brunk, Ph.D., of instruments developed by MACRO International, Inc., and the Mental Health Statistics Improvement Program (MHSIP/CMHS). The Outcome Specialists and the Children's Coordinating Council dropped several items. Many of these questions are answered in the UPMH Information System or are expected to be collected in the MIS in the future. The instruments are being piloted by several states, including Utah, so from time to time new test questions will be added by Utah and other states to test their effectiveness.

### *Data Collection Procedures*

**Who, When, How, and Where.** In the fiscal year a two-week period will be designated by DSAMH, during which time the YSS questionnaires are to be handed to **ALL** youth 13-17 years of age, who have been previously admitted to the CMHC and who are present in the clinic. A parent or adult caregiver in attendance with the youth will also be requested to complete the YSS-F. Parents and youth will be encouraged to complete the questionnaires independently. Support staff or researchers must hand out questionnaires while consumers are in-clinic. Clinicians must **not** hand the instrument to the client. Data are collected from youth, regardless of the type of program or modality of service to which admitted (e.g., outpatient, inpatient, residential, day treatment). **Parents or caregivers must also fill out questionnaires on children of all ages.**

### *Scoring and Data Analysis*

The questionnaires will be provided by the DSAMH in English and Spanish, or the online questionnaire may be used. After the two-week period has ended, questionnaires will be returned to the DSAMH for analysis. In addition, data will be made available on the DHS Data Warehouse so Centers and UBHN can perform further data analysis.

**YOUTH SERVICES SURVEY – YOUTH VERSION**

Please help our agency make services better by answering some questions about the services your child has received. Your answers will be kept confidential. Please indicate if you **Strongly Disagree, Disagree, Are Undecided, Agree, or Strongly Agree** with each of the statement below. Fill in the circle in the box that best describes your answer. Thank you!

<b>Local Authority:</b>  <input type="radio"/> Bear River Health Department <input type="radio"/> Bear River Mental Health <input type="radio"/> Central Utah MH/Substance Abuse <input type="radio"/> Davis Behavioral Health <input type="radio"/> Four Corners Community Behavioral Health, Inc. <input type="radio"/> Heber Valley Counseling <input type="radio"/> Northeastern Counseling <input type="radio"/> Salt Lake County Substance Abuse <input type="radio"/> San Juan Counseling <input type="radio"/> Southwest Center <input type="radio"/> Utah County Division of Substance Abuse <input type="radio"/> Valley Mental Health <input type="radio"/> Wasatch Mental Health <input type="radio"/> Weber Human Services <input type="radio"/> Other (specify): _____	<b>Date of Birth:</b>  <div style="text-align: center; margin-bottom: 10px;">         _/_/_/_/_/_/_/_          M M D D Y Y Y Y       </div> <table style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 5%; text-align: 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<b>When did you start getting services at this center for your current problems?</b> <input type="radio"/> 0-6 months <input type="radio"/> 7-11 months <input type="radio"/> 1-2 years <input type="radio"/> 3-5 years <input type="radio"/> more than 5 years																																																																																											

Would you like your therapist to see your answers to this questionnaire?

Yes     ☐  
 No      ☐

1. Overall, I am satisfied with the services I received.

2. I am better at handling daily life.
3. I get along better with family members.
4. I get along better with friends and other people.
5. I am doing better in school and/or work.
6. I am better able to cope when things go wrong.
7. I am satisfied with my family life right now.

[illegible]

8. I helped to choose my services.
9. I helped to choose my treatment goals.
10. The people helping me stuck with us no matter what.
11. I felt I had someone to talk to when he/she was troubled.
12. The people helping me listened to what he/she had to say.
13. I was actively involved in my treatment.
14. I received services that were right for me.
15. The location of services was convenient.
16. Services were available at times that were convenient me.
17. If I need services in the future, I would use these services again.
18. I got the help I wanted.
19. I got as much help as I needed.
20. I, not staff, decided my treatment goals.
21. Staff treated me with respect.
22. Staff understood my family's cultural traditions.
23. Staff respected my family's religious/spiritual beliefs.
24. Staff spoke with me in a way that I understood.
25. Staff were sensitive to my cultural/ethnic background.

[illegible]

26. **Were you arrested during the past 12 months?**  
☐ Yes  
☐ No
27. **Were you arrested during the 12 months prior to that?**  
☐ Yes  
☐ No
28. **Were you expelled or suspended during the past 12 months?**  
☐ Yes  
☐ No
29. **Were you expelled or suspended during the 12 months prior to that?**  
☐ Yes  
☐ No
30. **Since starting to receive services, the number of days I was in school is:**  
☐ greater  
☐ about the same  
☐ less  
☐ does not apply



31. What did you **LIKE** about our services?

32. What did you **NOT LIKE** about our services?

33. What could we do to **IMPROVE** our services?

*Thank you for taking the time to answer these questions!*

**YOUTH SERVICES SURVEY – PARENT OR CAREGIVER VERSION**

Please help our agency make services better by answering some questions about the services your child has received. Your answers will be kept confidential. Please indicate if you **Strongly Disagree, Disagree, Are Undecided, Agree, or Strongly Agree** with each of the statement below. Fill in the circle in the box that best describes your answer. Thank you!

<b>Local Authority:</b>  <input type="radio"/> Bear River Health Department <input type="radio"/> Bear River Mental Health <input type="radio"/> Central Utah MH/Substance Abuse <input type="radio"/> Davis Behavioral Health <input type="radio"/> Four Corners Community Behavioral Health, Inc. <input type="radio"/> Heber Valley Counseling <input type="radio"/> Northeastern Counseling <input type="radio"/> Salt Lake County Substance Abuse <input type="radio"/> San Juan Counseling <input type="radio"/> Southwest Center <input type="radio"/> Utah County Division of Substance Abuse <input type="radio"/> Valley Mental Health <input type="radio"/> Wasatch Mental Health <input type="radio"/> Weber Human Services <input type="radio"/> Other (specify): _____	<b>Date of Birth:</b>  <div style="text-align: center; margin-bottom: 10px;">         _/_/_/_/_/_/_/_          M M D D Y Y Y Y       </div> <table style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 5%; text-align: 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<b>Ethnicity</b> <input type="radio"/> Puerto Rican <input type="radio"/> Mexican <input type="radio"/> Cuban <input type="radio"/> Other Specific <input type="radio"/> Not of Hispanic Origin <input type="radio"/> Hispanic – Specific Origin Not Specified																																																																																											
<b>When did you start getting services at this center for your current problems?</b> <input type="radio"/> 0-6 months <input type="radio"/> 7-11 months <input type="radio"/> 1-2 years <input type="radio"/> 3-5 years <input type="radio"/> more than 5 years																																																																																											

**I give permission for my child's therapist to see my answers to this questionnaire?**

Yes     ☐  
 No      ☐

**How are you related to this child? (Fill in one)**

Mother             ☐  
 Father              ☐  
 Foster mother      ☐  
 Foster father       ☐  
 Other relative      ☐

- As a result of the services my child and/or family received:**

Strongly Disagree (1)	Disagree (2)	Undecided (3)	Agree (4)	Strongly Agree (5)
<b>O</b>	<b>O</b>	<b>O</b>	<b>O</b>	<b>O</b>

2. My child is better at handling daily life.
3. My child gets along better with family members.
4. My child gets along better with friends and other people.
5. My child is doing better in school and/or work.
6. My child is better able to cope when things go wrong.
7. I am satisfied with our family life right now.
8. My child is better able to do things he or she wants to do.

[illegible]

**Feedback about the services my child and/or family received:**

8. I helped to choose my child's services.
9. I helped to choose my child's treatment goals.
10. The people helping my child stuck with us no matter what.
11. I felt my child had someone to talk to when he/she was troubled.
12. The people helping my child listened to what he/she had to say.
13. I was frequently involved in my child's treatment.
14. The services my child and/or family received were right for us.
15. The location of services was convenient for us.
16. Services were available at times that were convenient for us.
17. If I need services for my child in the future, I would use these services again.
18. My family got the help we wanted for my child.
19. My family got as much help, as we needed for my child.
20. My child *and* family's needs determined my child's treatment goals.
21. Staff treated me with respect.
22. Staff understood my family's cultural traditions.
23. Staff respected my family's religious/spiritual beliefs.
24. Staff spoke with me in a way that I understood.
25. Staff were sensitive to my cultural/ethnic background.

[illegible]

**Other than my child's service providers:**

26. I know people who will listen and understand me when I need to talk.
27. In a crisis, I would have the support I need from family or friends.
28. I have people that I am comfortable talking with about my child's problems.
29. I have people that I am comfortable talking to about private things.
30. I have more than one friend.
31. I am happy with the friendships I have.
32. I have people with whom I can do enjoyable things.

[illegible]

- 33. Was your child arrested during the past 12 months?**

**O** Yes  
**O** No

- 34. Was your child arrested during the 12 months prior to that?**

**O** Yes  
**O** No

- 35. Was your child expelled or suspended during the past 12 months?**

**O** Yes  
**O** No

36. **Was your child expelled or suspended during the 12 months prior to that?**
- ☐ Yes
- ☐ No
37. **Since starting to receive services, the number of days my child was in school is:**
- ☐ greater
- ☐ about the same
- ☐ less
- ☐ does not apply
38. **What did you LIKE about our services?**
39. **What did you NOT LIKE about our services?**
40. **What could we do to IMPROVE our services?**

*Thank you for taking the time to answer these questions!*



# **Utah Public Mental Health Information System**

## **FILE SUBMISSION FORMATS**

### **For Clients and Events (Services)**

Mental Health Data Submission Requirements  
March 2005

Utah Division of Mental Health – UPMHIS 4/4/2002								
CLIENT FILE FORMAT								
Field #	Field Name	Description	Codes/Allowed Values	Max. Field Length	Format	Error Level	Example	Notes
1	RecordNo	Sequential Record Number	1, 2, ..., Number of records	10	N...N	1	1	Each record must have a sequential number beginning with 1.
2	ClientID	Client Identifier	Mapped value from MHO. (Unique client identifier)	15	X.....X	3		Client ID to be unique within the MHO and unique to each client admitted or readmitted to that MHO. It must not be reassigned to another client. Mapping must be consistent across quarters.
3	SSN	Social Security Number	Client Social Security Number	11	XXX-XX-XXXX	3		Use 000-00-0000 if unknown or is not available. Missing SSN updated quarterly by administrative staff.
4	DateAdm	Date of most recent client admission	Legal date	10	MM/DD/YYYY	3		Note: 4-character year
5	LegalSta	Legal Status at admission	Y- Civilly Committed N- Not Civilly Committed F- Forensic commitment - State Hosp only	1	X	1		
6	Gender	Gender	M Male F Female	1	X	3		
7	DateBir	Date of birth	Legal date	10	MM/DD/YYYY	3		Note: 4-character year
8	Hispanic	Hispanic or Latino origin	Y Yes N No	1	X	1		
9	Race	Race	1 American Indian 2 Asian 3 Black 4 White 5 Other 6 Alaskan Native 7 Pacific Islander	1	N	2		
10	Marital	Marital status	1 Never married 2 Now married 3 Separated 4 Divorced 5 Widowed	1	N	1		
11	Educatn	Completed years of education	0-21 (GED = 12)	2	NN	1		Education at admission
12	Income	Gross monthly household income at Admission	Actual gross monthly <u>household</u> income to the nearest dollar	5	NNNNN	1		Gross is the amount <u>before</u> taxes and other withholdings are taken out.
13	RefSrce	Source of referral at admission	1 Self 2 Family or friend 3 Physician or medical facility 4 Social or community agency 5 Educational system 6 Courts, law enforcement, correctional agency 7 Private psychiatric/mental health prog. 8 Public psychiatric/mental health prog. 9 Clergy 10 Private practice mental health professional	2	NN	1		

Utah Division of Mental Health – UPMHIS 4/4/2002								
CLIENT FILE FORMAT								
Field #	Field Name	Description	Codes/Allowed Values	Max. Field Length	Format	Error Level	Example	Notes
			11 Other persons or organizations					
14	FamSize	Total number in family who live at home	Code actual number in two digits	2	NN	1		
15	Veteran	Veteran status at admission	Y Yes N No	1	X	1		
16	Language	<b>What language needs to be spoken during therapy?</b> (admission only)	00 English 01 American sign language 02 Arabic 03 Bosnian 04 Cambodian 05 Chinese 06 Croatian 07 Farsi 08 French 09 Greek 10 German 11 Italian 12 Japanese 13 Kurdish 14 Laotian 15 Native American: Navajo 16 Native American: Ute 17 Russian 18 Samoan 19 Serbian 20 Somali 21 Spanish 22 Swahili 23 Tibetan 24 Tongan 25 Vietnamese 26 Zulu 27 Other (Specify in next question)	2	NN	1		Leave blank if English.
17	Languag2	If the response was 27 above, please write the “other” language that needs to be spoken during therapy	-----	20	XXXXXX..... ....	1		Leave blank if English or 01-26.
18	PrvTxAny	Previous mental health treatment of any kind	Y Yes N No X Unknown	1	X	1		
19	PrvTxUSH	Previous mental health treatment at the Utah State Hospital	Y Yes N No X Unknown	1	X	1		
20	PrvTxMH O	Previous mental health treatment at this mental health center	Y Yes N No X Unknown	1	X	1		



Mental Health Data Submission Requirements  
March 2005

Utah Division of Mental Health – UPMHIS 4/4/2002								
CLIENT FILE FORMAT								
Field #	Field Name	Description	Codes/Allowed Values	Max. Field Length	Format	Error Level	Example	Notes
21	ExpPaymt	Expected principal payment source (As reported by staff)	<b>1 Provider to pay most cost</b> 2 Personal resources 3 Commercial health insurance 4 Service contract 5 Medicare (Title XVIII) 6 Medicaid (Title XIX) 7 Veterans Administration 8 CHAMPUS 9 Workers compensation 10 Other public resources 11 Other private resources	2	NN	2		<b>Expected principal payment source is defined as the source expected to pay the highest percent of the cost. Staff should now report this, as is done for substance abuse clients.</b>  <b>Funding sources are too different at present to combine with Division of Substance Abuse.</b>
22	AdmGAF	GAF score at admission	1-99	2	NN	1		See DSM IV Axis V for definitions
23	Severity	Severity level (SED or SPMI)	Y Yes (SED or SPMI) N No (not SED or SPMI)	1	N	3		This required variable is to be updated at the 6-month case review. Specify if client meets the criteria for either SED or SPMI, depending on age.
24	DiagA1	Axis I Diagnosis 1	DSM IV Code	6	XNN.NN	3	296.32	This required variable is to be updated at the 6-month case review. Diagnosis deferred (799.9) is a valid code for Axis I.
25	DiagA2	Axis I Diagnosis 2	DSM IV Code	6	XNN.NN	1		An update is required if there is a second diagnosis on Axis I. Leave blank if no second diagnosis.
26	DiagA3	Axis I Diagnosis 3	DSM IV Code	6	XNN.NN	1		An update is required if there is a third diagnosis on Axis I. Leave blank if no third diagnosis
27	DiagB1	Axis II Diagnosis 1	DSM IV Code	6	XNN.NN	3	301.83	This required variable is to be updated at the 6-month case review if there is an Axis II diagnosis. Leave blank if no Axis II diagnosis.
28	DiagB2	Axis II Diagnosis 2	DSM IV Code	6	XNN.NN	1		An update is required if there is a second diagnosis on Axis II. Leave blank if no second diagnosis.
29	DiagB3	Axis II Diagnosis 3	DSM IV Code	6	XNN.NN	1		An update is required if there is a third diagnosis on Axis II. Leave blank if no third diagnosis.
30	Employmt	Employment status (Code only one. Items are listed in priority. If more than one is checked, code only highest priority. Staff, intake workers, or clinicians at admission may collect this information. However, only clinicians may report the data at each 6-month evaluation.)	1 Employed full time (35 hrs or more) 2 Employed part time (less than 35 hrs) 3 Supported/Transitional Employment 4 Homemaker 5 Student 6 Retired 7 Unemployed, seeking work 8 Unemployed, NOT seeking work 9 Disabled, not in labor force	1	N	3		Both supported and transitional employment involves the common element of support. However, transitional employment is time limited whereas supported employment is not. Both may include either MH or non-MH sponsorship.

**Utah Division of Mental Health – UPMHIS 4/4/2002**

**CLIENT FILE FORMAT**

Field #	Field Name	Description	Codes/Allowed Values	Max. Field Length	Format	Error Level	Example	Notes
31	LivingAr	Living arrangement (This information may be collected by staff, intake workers, or clinicians at admission. However, only clinicians may report the data at each 6-month evaluation.)	1 On the street or in a homeless shelter 2 Private residence <u>not requiring</u> support 3 Private residence <u>requiring</u> support 4 Jail or correctional facility 5 Institutional setting (NH, IMD, psych. IP, VA, state hospital) 6 24-hour residential care 7 Adult or child foster home	1	X	3		<u>Not requiring support</u> = does not require routine or planned support to maintain his/her/or family's independence in the living situation. <u>Requiring support</u> = requires support to maintain independence, including services for general health, mental health crises, recovery, or symptoms. Services are delivered at home by a family member or by an external care giver. May include case management.
32	DisabBli	Disability: blind	Y Yes N No	1	X	1	N	
33	DisabDea	Disability: deaf	Y Yes N No	1	X	1	N	
34	DisabOrg	Disability: organic	Y Yes N No	1	X	1	Y	
35	DisabAmb	Disability: ambulatory	Y Yes N No	1	X	1	N	
36	DisabInt	Disability: intellectual	Y Yes N No	1	X	1	N	
37	County	County of residence at admission	001 Beaver 003 Box Elder 005 Cache 007 Carbon 009 Daggett 011 Davis 013 Duchesne 015 Emery 017 Garfield 019 Grand 021 Iron 023 Juab 025 Kane 027 Millard 029 Morgan 031 Piute 033 Rich 035 Salt Lake 037 San Juan 039 Sanpete 041 Sevier 043 Summitt 045 Tooele 047 Uintah 049 Utah 051 Wasatch	3	XXX	2		

Mental Health Data Submission Requirements  
March 2005

Utah Division of Mental Health – UPMHIS 4/4/2002								
CLIENT FILE FORMAT								
Field #	Field Name	Description	Codes/Allowed Values	Max. Field Length	Format	Error Level	Example	Notes
			053 Washington 055 Wayne 057 Weber					
38	DateDisc	Date of discontinuation or discharge	Legal date	10	MM/DD/YYYY	3		Note:4-character year
39	RefDisc	Referral at discontinuation or discharge	Not yet discontinued 0 Self ( <b>code as 14-not referred</b> ) 1 Family or friend ( <b>code as 14</b> ) 2 Physician, medical facility 3 Social or community agency 4 Educational system 5 Courts, law enforcement, correctional agency 6 Private psychiatric or private mental health program 7 Public psychiatric or public mental health program 8 Clergy 9 Private practice mental health profess. 10 Other person or organization 11 Deceased 12 Dropped out of treatment 13 Not referred ( <b>see notes to 1 and 2</b> )	2	NN	1		<b>Code: not yet discontinued as “0,” self as “not referred” (14) and family or friend as “not referred” (14).</b>  <b>The codes are too different at present to combine with Division of Substance Abuse.</b>
40	TxComplt	Treatment completion at discontinuation	1 Completed/substantially completed 2 Mostly completed 3 Only partially completed 4 Mostly not completed 5 Does not apply (Evaluation only)	1	N	1		
41	County (USH only)	Referral county at discharge	001 Beaver 003 Box Elder 005 Cache 007 Carbon 009 Daggett 011 Davis 013 Duchesne 015 Emery 017 Garfield 019 Grand 021 Iron 023 Juab 025 Kane 027 Millard 029 Morgan 031 Piute 033 Rich 035 Salt Lake 037 San Juan 039 Sanpete	3	XXX	2		

Utah Division of Mental Health – UPMHIS 4/4/2002 CLIENT FILE FORMAT								
Field #	Field Name	Description	Codes/Allowed Values	Max. Field Length	Format	Error Level	Example	Notes
			041 Sevier 043 Summitt 045 Tooele 047 Uintah 049 Utah 051 Wasatch 053 Washington 055 Wayne 057 Weber					

Mental Health Data Submission Requirements  
March 2005

Utah Public Mental Health Information System: Event (Service) Input File Format 2/11/2002 (one or more records as required)								
EVENT DATA RECORD FORMAT								
Field #	Field Name	Description	Codes/Allowed Values	Max Field Length	Format*	Error Level	Example	Notes
1	RecordNo	Sequential record number	1,2,..., Number of records	10	n...n	3		Each record must have a sequential number beginning with “1.”
2	DateEvent	Date of event	Any legal date	10	mm/dd/yyyy	3	03/01/2002	Use four digits for the year.
3	ClientID	ID of client involved in the event	Client ID	15	x...x	3		Client ID must be consistent from quarter to quarter and from year to year.
4	ProgramID	Program element identifier	10 Inpatient (Days) 21A Residential adult treatment (Days) 21Y Residential youth treatment (Days) 22 Residential support (Days) 23 Housing/in-home skills (Days) 30 Partial day (Hours) 40 Outpatient (Hours) 50 Case management (Hours) 60 Emergency, clients only (Hours) 70 Family support (hours)	3	x...x	3	40	
			10 Engagement: direct service, non-Treatment 21 Screening/triage, diagnosis, & assessment: direct service, non-treatment 22 Initial diagnosis & assessment: direct service, non-treatment 23 Other diagnosis & assessment: direct service, non-treatment 24 Testing, diagnosis & assessment: direct service, non-treatment 30 Individual: direct service, treatment 40 Family: direct service, treatment 50 Group: direct service, treatment 61 Medication management: direct service, treatment, physician 62 Medication management: direct service, treatment, nurse 70 Rehabilitation: direct service, Rehabilitation 80 Vocational training: direct service, Rehabilitation 90 Social/physical, direct service, Rehabilitation					

Utah Public Mental Health Information System: Event (Service) Input File Format 2/11/2002 (one or more records as required)								
EVENT DATA RECORD FORMAT								
Field #	Field Name	Description	Codes/Allowed Values	Max Field Length	Format*	Error Level	Example	Notes
			100 Skill building, direct service, rehabilitation 110 Other direct service, rehabilitation 120 Personal care-giving activities, direct services 130 Case management adjunctive service 140 Other adjunctive service 150 Respite care 160 Behavioral 170 CLIENT DAY 180 Emergency hours					
6	EventDuration	Duration of event in either days or hours (see notes)	Number of hours or days	6	nnn.nn	See notes	1.75	Value is in either days or hours depending on the program element identifier and type of event. Refer to the program element vs. service type matrix. Hours may be expressed as decimal fractions rounded to the nearest quarter hour (e.g., one hour and 45 minutes = 1.75). Days may <u>not</u> be reported in decimals. No more than one day may be reported for each event per day.
7	FundingSrc	Funding source	1 Medicaid 2 Not Medicaid	1	n		1	Medicaid funding is determined retroactively. Code "1" if client is on the Medicaid monthly eligibility list for the month services were received, "2" if not on that list.

**\*Codes used in format description:**

mm = two digit month ( 02, 12, etc.)

dd = two digit date (03, 25, etc.)

yyyy = four digit year (2002, 2003, etc)

x = any legal character (may be alpha or numeric)

n = any single digit (0, 1, 2, etc) (must be numeric)

n...n = one or more digits up to the maximum allowed

Blank in error level "1" or "2" = UNKNOWN

Blanks in error level "3" are NOT allowed

Data should be provided for all fields in each record if available. If data are missing in a required field (error level "3"), the record will be rejected by the UPMHIS. Some level of missing is acceptable in non-required fields ("1" or "2.") Refer to the CMHC contract for provisional standards for FY 2003.

## **Other Documents Available Upon Request**

First request [by letter] to adult client to complete Consumer Self Assessment (GWBPLUS)

Second request [by letter] to adult client to complete Consumer Self Assessment (GWBPLUS)

Follow-up letter to adult client contacted by phone to complete Consumer Self Assessment (GWBPLUS)

First request [by letter] to complete the Y-OQ<sup>R</sup>-30.1 (parents and youth)

Second request [by letter] to complete the Y-OQ<sup>R</sup>-30.1 (parents and youth)

First Request [by letter] to complete the Youth Services Survey (parents and youth)

Second Request [by letter] to completed Youth Services Survey (parents and youth)

Department of Human Services, Institutional Review Board (IRB) Policy and Procedures

[http://www.dhs.utah.gov/pol\\_reports.htm](http://www.dhs.utah.gov/pol_reports.htm) (The IRB was established to protect the rights of human research subjects)

### **Substance Abuse Data Reporting Deadlines**

All TEDS data submissions are to be sent electronically according the following schedule:

<b>Reporting Period</b>	<b>Deadline</b>
Quarter 1 (July 1 – September 30)	October 31
Quarter 2 (October 1 – December 31)	January 31
Quarter 3 (January 1 – March 31)	April 30
Quarter 4 (April 1 – June 30)	July 31



# Treatment Episode Data Set (TEDS)

## File Format and Definitions

### Official Document for FY 2005 Data Submission

Two documents, the Client Data Record Format and the TEDS Definitions, have been combined into one document to make it easier to know what is required. The last column in the following table is labeled “Code” and is used to describe each element as follows:

#### **Codes**

**KEY:** These fields are used to match discharge records with admission records. These data must be complete and accurate for both admission and discharge records.

**ADMIT:** These fields are used for admission data and may be blank if the record contains only discharge data.

**DISCH:** These fields are used for discharge data and may be blank if the record contains only admission data.

**FED:** These fields are required by the Federal Substance Abuse and Mental Health Administration.

**FED-S:** Part of TEDS Supplemental Data Set - we are collecting these.

**STATE:** These fields are not required by the Federal Substance Abuse and Mental Health Administration. Status pending.

**STATE-R:** These fields are not required by the Federal Substance Abuse and Mental Health Administration, but are required by DSAMH.

**TRANS:** Only the Transaction Type field has this code and its properties are described in the following table.

## Supplemental Definitions

**Client:** A person who meets all of the following criteria:

1. has an alcohol or drug related problem,
2. has completed the screening and intake process,
3. has been formally admitted for treatment or recovery service in an Alcohol or Drug Treatment unit operated or funded (fully or partially) by a State Alcohol or State Drug Authority, and
4. has his or her own client record.

If a person has only completed the assessment process and it is determined that he/she does not need treatment and therefore does not meet all of the above criteria of a client, the person can still be included as a TEDS admission but must have a code of “Assessment ONLY” in the *Service/Program Type*.

*(A person is **not** a client if he/she has only completed a screening or intake process or has been placed on a waiting list.)*

**Service/Program Type: (Field #9)** – the service that the client is admitted or transferred into.

Assessment Only: This code should be used if a person has only completed the assessment process (has not been formally admitted into substance abuse treatment) and it is determined that he/she does not need substance abuse treatment and therefore does not meet all of the criteria of a client. Remember that these individuals do not meet the federal definition of a client for TEDS reporting purposes.

Detoxification, 24-hour service, Hospital Inpatient: 24-hour per day medical acute care services for detoxification for persons with severe medical complications associated with withdrawal. To qualify under this service type, the service must also meet the specifications as outlined under **ASAM Level IV-D or Level III.7-D** which are as follows: 1) an organized service delivered by medical and nursing professionals that provides for 24-hour medically-directed evaluation and withdrawal management in an acute care inpatient setting. Services are delivered under a defined set of physician-approved policies and physician-managed procedures or medical protocols. Or, 2) an organized service delivered by medical and nursing professionals, which provides for 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds

Detoxification, 24-hour service, Free-Standing Residential: 24-hour per day services in non-hospital setting providing for safe withdrawal and transition to ongoing treatment. To qualify under this service type, the service must also meet the specifications as outlined under **ASAM Level III.2-D** which are as follows: an organized service delivered by appropriately trained staff, who provide 24-hour

supervision, observation and support for patients who are intoxicated or experiencing withdrawal.

Rehabilitation/Residential, Hospital (other than detoxification): 24 hour per day medical care in a hospital facility in conjunction with treatment services for alcohol and other drug abuse and dependency. To qualify under this service type, the service must also meet the specifications as outlined under **ASAM Level IV** which are as follows: an organized service, staffed by designated addiction physicians or addiction credentialed clinicians and requires an interdisciplinary staff to care for patients whose acute biomedical, emotional or behavioral problems are severe enough to require primary medical and nursing services. Treatment is provided 24 hours a day, and the full resources of a general acute care hospital or psychiatric hospital are available.

Rehabilitation/Residential, Short Term: Typically 30 days or less of non-acute care in a setting with treatment services for alcohol and other drug abuse and dependency. To qualify under this service type, the service must also meet the specifications as outlined under **ASAM Level III.7 or Level III.5** which are as follows: Level III.7—an organized service, staffed by designated addiction treatment personnel or addiction-credentialed physicians, that provides a planned regimen of 24-hour professionally directed evaluation, care and treatment for addicted patients in an inpatient setting. Twenty-four hour observation, monitoring and treatment are available, however, the full resources of an acute care general hospital or a medically-managed inpatient treatment service system are not necessary. Level III.5—programs designed to address significant problems with living skills, that are accurately characterized by the intensity of the addiction treatment services and the highly structured program activity, where the resident's activities are prescribed 24 hours a day until the resident demonstrates specified treatment progress. With increased staff training and nursing supervision, programs at this level are able to address the medical needs of residents who have slightly more severe medical problems.

Rehabilitation/Residential, Long Term: Typically more than 30 days of non-acute care in a setting with treatment services for alcohol and other drug abuse and dependency; this may include transitional living arrangements such as half way houses. To qualify under this service type, the service must also meet the specifications as outlined under **ASAM Level III.1 or Level III.3** which are as follows: Level III.1—offers low-intensity professional addiction treatment services at least 5 hours a week. This level of care is best understood in its component parts. The professional addiction treatment services provided in this setting are low-intensity outpatient services focused on problems in applying recovery skills. The other component is a structured recovery environment, staffed 24 hours a day. Level III.3—provide a structured recovery environment in combination with medium-intensity professional clinical services to support and promote recovery. Services generally are considered to be of medium intensity and are presented at a

slower pace than in more intensive residential programs. Persons who are appropriately placed in this level of care are characterized by their need for a slower paced treatment presentation because of mental health problems or reduced cognitive functioning or the chronicity of their illness.

**Ambulatory, Intensive Outpatient:** As a minimum the client must receive treatment lasting two or more hours per day three or more days per week. To qualify under this service type, the service must also meet the specifications as outlined under **ASAM Level II.5 or Level II.1** which are as follows: involves a structured day or evening treatment program that may be offered before or after work or school, in the evening or on a weekend. Programs have the capacity to arrange for medical and psychological consultation, psychopharmacological consultation and 24-hour crisis services. In addition, they have active affiliations with other levels of care and can assist in accessing clinically necessary “wraparound” support services such as child care, transportation and vocational training. Distinctions are made among various subtypes of Level II program as follows: Level II.5) Generally provides 20 or more hours of clinically intensive programming per week based on individual treatment plans. Programs have ready access to psychiatric, medical and laboratory services. Level II.1) Generally provide nine or more hours of structured programming per week, consisting primarily of counseling and education around alcohol and other drug problems. The patient’s needs for psychiatric and medical services are addressed through consultation or referral arrangements. II.1 differs from II.5 in the intensity of clinical services that are directly available: specifically, II.1 has less capacity to effectively treat individuals who have substantial medical and psychiatric problems.

**Ambulatory, Non-Intensive Outpatient:** Treatment services including individual, family and/or group services; these may include pharmacological therapies. To qualify under this service type, the service must also meet the specifications as outlined under **ASAM Level I** which are as follows: organized non-residential services, which may be delivered in a wide variety of settings. Addiction treatment personnel or addiction credentialed clinicians provides professionally directed evaluation, treatment and recovery services to persons with substance-related disorders. Such services are provided in regularly scheduled sessions of usually fewer than 9 contact hours a week.

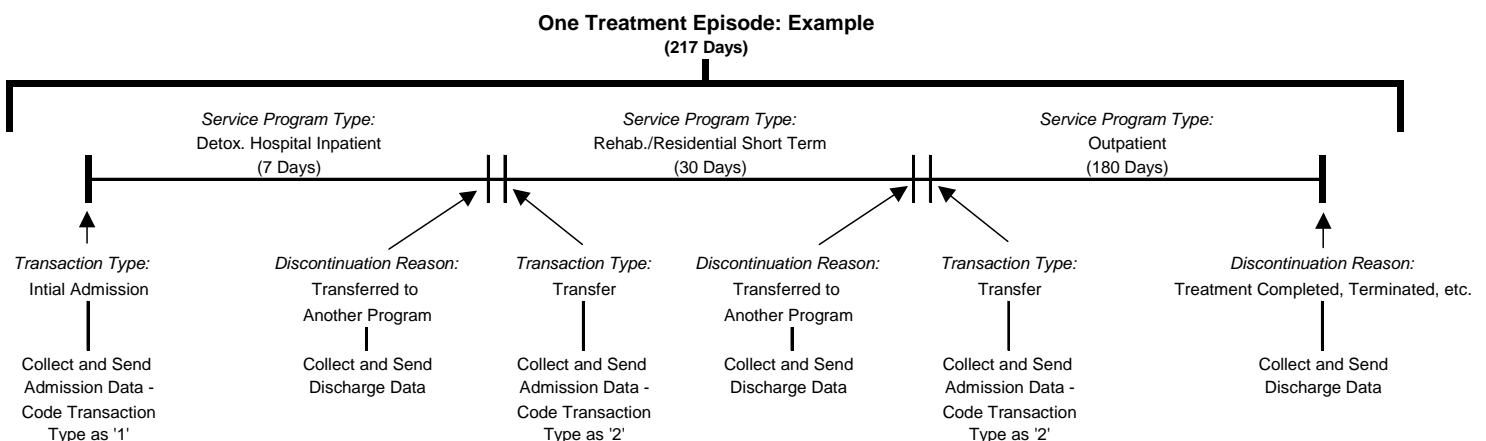
**Ambulatory, Detoxification:** Outpatient treatment services providing for safe withdrawal in an ambulatory setting – pharmacological or non-pharmacological. To qualify under this service type, the service must also meet the specifications as outlined under **ASAM Level I-D, or Level II-D** which are as follows: 1) an organized outpatient service, which may be delivered in an office setting, healthcare or addiction treatment facility, or in a patient’s home, by trained clinicians who provide medically supervised evaluation, detoxification and referral services according to a pre-determined schedule. Or 2) an organized outpatient service, which may be delivered in an office setting, healthcare or addiction treatment

facility, by trained clinicians who provide medically supervised evaluation, detoxification and referral services according to a pre-determined schedule. Essential to this level of care is the availability of appropriately-credentialed and licensed nurses (R.N., L.P.N.) for monitoring of patients over a period of several hours each day of service.

**Limited Treatment:** If a provider of services would like to submit data to the State for clients who are receiving services they would define as “limited treatment,” the provider must submit a separate explanation or description of specifically what these services are. However, with the implementation of the new DUI curriculum, it will no longer be necessary or appropriate to report those clients under these services—we will be collecting information on those clients separately. It should also be noted, that any clients reported to the State under this service type will not be included in any statistical reports produced by the State.

**Treatment Episode:** the period of service between the initiation of substance abuse treatment services for a client with a drug or alcohol abuse or dependency problem and the termination of services for that client, where no significant break in services has occurred. There is only one initial admission per episode. Therefore, if a client in the midst of a single episode of treatment changes services/modalities or providers, this event is considered a “**transfer**” rather than a new initial admission. For example, a client who has been in detoxification may complete this level of service and be transferred to a residential setting within the same treatment episode. This transaction should be reported as a **transfer**, not a new initial admission. **All required data elements are the same for admission and transfer records. The only difference is the coding of the transaction type.** A treatment episode should be assumed to have ended, and the client officially discharged from the treatment episode (if not discharged already), if the client has not been seen in 5 days in the case of an inpatient or residential, 14 days in the case of day treatment and 60 days in the case of an intensive or general outpatient.

**Clients returning for services after the elapsed time described need to be reported as an initial admission to a subsequent treatment episode.**



Utah Division of Substance Abuse and Mental Client File Format for TEDS - FY2005

#	Name and Description	Allowed Values	Format	Definition	Code
1	RecordNo Record Number	1,2,..., (Number of Records)	number (10)	A sequential count of the records submitted each quarter. This field is NOT used to match records.	
2	provider_id Provider ID	Utnnnn	string (15)	Identifies the provider of the alcohol or drug treatment service, the provider's National Facility Register (NFR) number. Must begin with "UT."	KEY FED
3	client_id Client ID	Unique Client identifier	string (15)	An identifier that is from 1 to 15 alphanumeric characters and at a minimum is unique within the provider. The identifier: 1. Must NOT be reassigned to another client, 2. Can be meaningless, and 3. Must ensure confidentiality of client records - must not identify the client.	KEY FED
4	ssn Social Security Number	Client's SSN 999-99-9999=None 000-00-0000=Unknown	string (15)	The client's social security number.	KEY FED
5	medicaid_id Medicaid Number	Clients Medicaid ID Number 0000000097=Unknown 0000000098=Not Applicable	string (10)	The client's Medicaid number.	ADMIT STATE
6	depen_collat_ind Co-Dependent/ Collateral	1=Yes 2=No	number (1)	A person who has no alcohol or other drug abuse problem, but satisfies all of the following conditions: 1. Is seeking services because of problems arising from his/her relationship with an alcohol or drug abuser. 2. Has been formally admitted for service to a program. 3. Has his/her own client record within a primary client record.	ADMIT FED
7	trans_type_cd Transaction Type	1=Initial Admit (Beginning of Episode) 2=Transfer/Change in Service Blank=Discharge data only - (Will not import any admission data)	number (1)	This tells if the client is being admitted as an "initial admit" (beginning of the treatment episode) or a "transfer" (change of service or provider) within an episode. Leave blank if discharge ONLY record (the error checker will ignore admission data, except key fields).	TRANS FED
8	admit_dt Date of Admission	Legal Date	mm/dd/yyyy	The month, day and year when the client receives his or her first direct treatment or recovery service.	KEY ADMIT FED
9	service_prog_cd Service/Program Type	0=Assessment Only 1=Detox. Hospital Inpat. 2=Detox. Free Standing 3=Rehab/Res. Hospital 4=Rehab./Res. Short Term 5=Rehab./Res. Long Term 6=Amb. Intensive Outpatient 7=Amb. Outpatient 8=Amb. Detox. 9=Limited Treatment	number (1)	The service that the client is admitted or transferred into. See Supplemental Definitions for the definition of each service type.	ADMIT FED

#	Name and Description	Allowed Values	Format	Definition	Code
10	initial_diagnosis_cd Initial Diagnosis DSM IV	291.xx 292.xx 303.xx 304.xx 305.xx 799.xx V-Codes 997.97=Unknown	string (6)	Use the specific DSM IV numeric code for the Axis I Substance Abuse diagnosis; if the client uses multiple drugs, be sure to use the polysubstance abuse DSM IV numeric code. All numeric codes must begin with one of the following 3 digit combinations, indicating some form of substance abuse or dependence: "303," "304," "305," "291," "292," "799," or a "V" code. If the clients diagnosis has not yet been determined, use the code 999.97 for "Unknown."	ADMIT FED-S
11	prior_episode_id Number of Prior Treatment Episodes	0=0 Prior Treatments 1=1 Prior Treatment 2=2 Prior Treatments 3=3 Prior Treatments 4=4 Prior Treatments 5=5 or More Prior Treatments 7=Unknown	number (1)	The number of previous treatment episodes the client has received in any drug or alcohol program. Changes in service/modality during the same treatment episode should not be counted as separate episodes. Also, the count should not include episodes prior to 1/1/90.	ADMIT FED
12	referral_source_cd Source of Referral at Admission	1=Individual Includes Self 2=Alcohol/Drug Abuse Care Provider 3=Other Health Care Provider 4=School 5=Employer/EAP 6=Division of Workforce Services-Welfare 7=DCFS 8=Adult Court 9=Juvenile Court 10=Probation 11=Parole 12=Police 13=Prison 14=DUI/DWI 15=Other Community Referral 97=Unknown	number (2)	Describes the specific person or agency referring the client to the alcohol or drug treatment program. <u>Individual</u> (includes self-referral): Includes the client, a family member, friend or any other individual that would not be included in any of the following categories. Includes self-referral due to pending DWI/DUI. <u>Alcohol/Drug Abuse Care Provider</u> : Includes any program, clinic, or other health care provider whose principal objective is treating clients with substance abuse programs, or a program whose activities are related to alcohol or drug abuse prevention, education or treatment.  <u>Other Health Care Provider</u> : Includes a physician, psychiatrist, or other licensed health care professional; or general hospitals, psychiatric hospitals, mental health programs or nursing homes. <u>School</u> (Educational): Includes a principal, counselor, or teacher; or a student assistance program (SAP), the school system, or an educational agency.  <u>Employer/EAP</u> : Includes a supervisor or an employee counselor. <u>Adult Court</u> : include adult drug or dependency courts in this category. <u>Juvenile Court</u> : include juvenile drug courts in this category. <u>DUI/DWI</u> : referral by a court for DWI/DUI. <u>Other Community Referral</u> : Community and religious organizations or any federal, State or local agency that provides aid in the areas of poverty relief, unemployment, shelter or social welfare, that is not listed above. Self-help groups such as AA, Al-Anon, and NA are also included in this category.	ADMIT FED

#	Name and Description	Allowed Values	Format	Definition	Code
13	birth_dt Date of Birth	Legal Date 01/01/0007=Unknown	mm/dd/yyyy	The client's legal date birth. This field should only be coded as "unknown" (01/01/0007) if the client was admitted into detoxification services and the client left services prior to being capable of providing this information.	ADMIT FED
14	gender_cd Gender	1=Male 2=Female	number (1)	Identifies the client's gender.	ADMIT FED
15	race_cd Race	1=Alaskan Native 2=American Indian 3=Asian 4=Native Hawaiian or Other Pacific Islander 5=Black/African American 6=White 7=Unknown 0=Other	number (1)	Indicates the client's race. If you don't distinguish between American Indian and Alaska Native, code both as American Indian. Clients of Hispanic ethnicity are typically coded as "White" in the racial category. <u>Alaska Native:</u> (Aleut, Eskimo, Indian) Origins in any of the original people of Alaska. <u>American Indian:</u> (Other than Alaska Native) Origins in any of the original people of North American and South America (including Central America) and who maintain cultural identification through tribal affiliation or community attachment. <u>Asian:</u> Origins in any of the original people of the Far East, the Indian subcontinent, Southeast Asia, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Philippine Islands, Thailand, Vietnam. <u>Native Hawaiian or Other Pacific Islander:</u> Origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. <u>Black or African American:</u> Origins in any of the black racial groups of Africa. <u>White:</u> Origins in any of the original people of Europe, North Africa or the Middle East. <u>Other:</u> A default category for use in instances in which the client is not classified above or whose origin group, because of area custom, is regarded as a racial class distinct from the above categories.	ADMIT FED
16	ethnicity_cd Ethnicity	1=Puerto Rican 2=Mexican 3=Cuban 4=Other Hispanic 5=Not of Hispanic Origin 7=Unknown	number (1)	Identifies the specific Hispanic Origin. <u>Puerto Rican:</u> Of Puerto Rican origin regardless of race. <u>Mexican:</u> Of Mexican origin regardless of race. <u>Cuban:</u> Of Cuban origin regardless of race. <u>Other Specific Hispanic:</u> Of known or unknown Central or South American or any other Spanish cultural origin (including Spain), other than Puerto Rican, Mexican or Cuban, regardless of race.	ADMIT FED
17	marital_status_cd Marital Status	1=Never Married 2=Married 3=Separated 4=Divorced 5=Widowed 7=Unknown		Specifies the client's marital status. <u>Never Married:</u> Includes those whose only marriage was annulled. <u>Married:</u> Includes those living together as married. <u>Separated:</u> Includes those separated legally or otherwise absent from spouse because of marital discord.	ADMIT FED-S



#	Name and Description	Allowed Values	Format	Definition	Code
18	education_cd Education	0=Less than One Grade Completed 1-25=Years of School (Highest Grade) Completed (For GED use 12) 97=Unknown	number (2)	Specify the highest school grade the client has completed.	ADMIT FED
19	employment_cd Employment Status at Admission	1=Employed Full Time 2=Employed Part time 3=Unemployed 4=Homemaker 5=Student 6=Retired 7=Disabled 8=Inmate of an Institution 20=Other "Not In the Labor Force" 97Unknown	number (2)	Identifies the client's current employment status. <u>Employed Full Time</u> : Working 35 hours or more each week, including members of the uniformed service. <u>Employed Part Time</u> : Working fewer than 35 hours each week. <u>Unemployed</u> : Looking for work during the past 30 days or on layoff from a job. <u>Inmate of an institution</u> : Prison or an institution that keeps a person, otherwise able, from entering the labor force. <u>Other "Not in the Labor Force"</u> : Not looking for work during the past 30 days.	ADMIT FED

#	Name and Description	Allowed Values	Format	Definition	Code
20	pri_substance_cd Substance Code Primary at Admission	1=None 2=Alcohol 3=Cocaine/Crack 4=Marijuana/Hashish 5=Heroin 6=Non-Prescription Methadone 7=Other Opiates/Synthetics 8=PCP 9=Other Hallucinogens 10=Methamphetamine 11=Other Amphetamines 12=Other Stimulants 13=Other Benzodiazepines 14=Other Tranquilizers 15=Barbiturates 16=Other Sedatives/Hypnotic 17=Inhalants 18=Over the Counter 30=Oxycodone (Oxycotin, Percocet) 31=LSD 32=Methylphenidate (Ritalin) 33=Alprazolam (Xanax) 34=Diazepam (Valium) 35=Lorazepam (Ativan) 36=Hydrocodone (Vicodin, Lortab) 37=Morphine (ms contin) 38=MDMA (Ecstasy) 39=Rohypnol 40=GHB/GBL 41=Ketamine (Special K) 42=Clonazepam (Klonopin, Rivotril) 20=Other 97=Unknown	number (2)	Identifies the client's primary substance problem. This field can only be coded as "unknown" (97) if the client was admitted into detoxification services and the client left services prior to being capable of providing this information. This field must be coded as "none" (1) if and only if the client was admitted as co-dependent/collateral.	ADMIT FED
21	sec_substance_cd Substance Code Secondary at Admission	Same as Field 20	number (2)	Identifies the client's second substance problem.	ADMIT FED
22	ter_substance_cd Substance Code Primary at Admission	Same as Field 20	number (2)	Identifies the client's third substance problem.	ADMIT FED

#	Name and Description	Allowed Values	Format	Definition	Code
23	pri_admin_route_cd Route of Administration- Primary	0=Other 1=Oral (Swallowed) 2=Smoking 3=Inhalation (Fumes) 4=lv Injection 5=Non-lv Injection 6=Nasal (Snorted, Sniffed) 7=Unknown 8=Not Applicable	number (1)	The way the client usually administers his/her primary substance of abuse. This field should be coded as “unknown” (7) only if the client’s <i>Substance Code Primary at Admission</i> was also coded as “unknown” (97). This field must be coded as “not applicable” (8) if and only if the client’s <i>Substance Code Primary at Admission</i> was coded as “none” (1).	ADMIT FED
24	sec_admin_route_cd Route of Administration- Secondary	Same as field 23	number (1)	The same as Route of Administration – Primary, but for the client’s secondary substance.	ADMIT FED
25	ter_admin_route_cd Route of Administration- Tertiary	Same as field 23	number (1)	The same as Route of Administration – Primary, but for the client’s tertiary substance.	ADMIT FED
26	pri_frequency_use_cd Frequency of Use - Primary at Admission	1=No Use During Last 30 Days 2=1-3 Times During Last 30 Days 3=1-2 Times Per Week During Last 30 Days 4=3-6 Times Per Week During Last 30 Days 5=Daily Use During Last 30 Days 7=Unknown 8=Not Applicable	number (1)	Identifies the approximate number of times the primary substance of abuse was used during the last 30 days that the client was not in a controlled environment, e.g. prison/jail. This field should be coded as “unknown” (7) only if the client’s <i>Substance Code Primary at Admission</i> was also coded as “unknown” (97). This field must be coded as “not applicable” (8) if and only if the client’s <i>Substance Code Primary at Admission</i> was coded as “none” (1).	ADMIT FED
27	sec_frequency_use_cd Frequency of Use - Secondary at Admission	Same as field 26	number (1)	Identifies the approximate number of times the secondary substance of abuse was used during the last 30 days that the client was not in a controlled environment, e.g. prison/jail. This field must be coded as “not applicable” (8) if and only if the client’s <i>Substance Code Secondary at Admission</i> was coded as “none” (1).	ADMIT FED
28	ter_frequency_use_cd Frequency of Use - Tertiary at Admission	Same as field 26	number (1)	Identifies the approximate number of times the secondary substance of abuse was used during the last 30 days that the client was not in a controlled environment, e.g. prison/jail. This field must be coded as “not applicable” (8) if and only if the client’s <i>Substance Code Tertiary at Admission</i> was coded as “none” (1).	ADMIT FED

#	Name and Description	Allowed Values	Format	Definition	Code
29	pri_first_use_age Age of First Use - Primary	0-96=Age 97=Unknown 98=Not Applicable	number (2)	For drugs other than alcohol, this field identifies the first voluntary use of the substance in the corresponding primary substance of abuse. For alcohol as the primary substance, it is the age of first intoxication. This field should be coded as "unknown" (97) if the client's <i>Substance Code Primary at Admission</i> was also coded as "unknown" (97). This field must be coded as "not applicable" (98) if and only if the client's <i>Substance Code Primary at Admission</i> was coded as "none" (1).	ADMIT FED
30	sec_first_use_age Age of First Use - Secondary	Same as field 29	number (2)	The same as the Age of First Use – Primary, but for the secondary substance of abuse.	ADMIT FED
31	ter_first_use_age Age of First Use - Tertiary	Same as field 29	number (2)	The same as the Age of First Use – Primary, but for the tertiary substance of abuse.	ADMIT FED
32	living_arrangment_cd	1=Homeless 2=Dependent 3=Independent 7=Unknown	number (1)	Specifies if the client is homeless, living with parents or in a supervised setting, or living on his or her own. <u>Homeless</u> : No fixed address, including shelters. <u>Dependent</u> : Clients living in a supervised setting such as a residential institution, halfway house or group home, and children (under age 18) living with parents, relatives, or guardians or in foster care. <u>Independent</u> : Clients living alone or with others without supervision. *Use the patient's living status immediately prior to entering treatment UNLESS the patient is incarcerated and has been in the unit of incarceration for less than 30 days when he/she is admitted into treatment, in which case the living status immediately prior to being incarcerated should be used. If the patient has been incarcerated for 30 days or longer upon being entered into treatment, the Dependent code should be used. *If the patient is in a Dependent setting immediately prior to entering treatment, code them as Dependent even if he/she has a place of Independent residence. *A patient may be coded as Homeless at admission even if he/she is entering treatment immediately after being discharged from a subsequent modality of treatment in a dependent setting and/or being released from a unit of incarceration. Even though the patient may have come from a Dependent setting, he/she may not have a fixed address at the point of admission.	ADMIT FED

#	Name and Description	Allowed Values	Format	Definition	Code
33	primary_income_cd Primary Source of Income	1=Legal Employment, Wages and Salary 2=Welfare, Public Assistance 3=Pension, Retirement Benefits, Social Security 4=Disability, Worker's Compensation 5=Other 6=None 7=Unknown	number (1)	Identifies the client's principal source of financial support. For children under 18, this field indicates the parent's primary source of income/support.	ADMIT FED-S
34	health_insurance_code Health Insurance	1=Private Insurance 2=Blue Cross/ Blue Shield 3=Medicare 4=Medicaid 5=HMO 6=Other (Champus) 7=Unknown 8=None 9=CHIP	number (1)	Specifies the client's health insurance. The insurance may or <b>may not</b> cover alcohol or drug treatment.	ADMIT FED-S
35	payment_source_cd Expected Source of Payment	1=Self Pay 2=Blue Cross/ Blue Shield 3=Medicare 4=Medicaid 5=Other Government Payments 6=Worker's Compensation 7=Other Health Insurance Co. 8=No Charge/Free/Charity 9=CHIP 10=CIAO 11=Drug Court 20=Other 97=Unknown	number (2)	Identifies the primary source of payment for the current treatment event/modality. Those clients operating under a split payment fee arrangement between multiple payment sources are to default to the payment source with the largest percentage. When the payment percentages are equal, either one can be selected.	ADMIT FED-S
36	methadone_ind Opiod Replacment Therapy	1=Yes 2=No 7=Unknown	number (1)	Identifies the planned or actual use of methadone, LAAM, Buprenorphine or other opioid replacement therapy as part of the client's treatment plan.	ADMIT FED
37	pregnant_ind Pregnant at Time of Admission	1=Yes 2=No 7=Unknown	number (1)	Identifies whether or not the client is pregnant at admission.	ADMIT FED-S
38	psychiatric_ind Psychiatric Problem	1=Yes 2=No 7=Unknown	number (1)	Identifies whether the client has a psychiatric problem (a DSM Axis I or II Diagnosis) <b>in addition</b> to his/her alcohol or drug use problem.	ADMIT FED-S
39	wait_days_nbr Time Waiting to Enter Treatment	0-996=Number of Days 997=Unknown	number (3)	Indicates the number of days from the first contact or request for service until the client was admitted and the first clinical service was available.	ADMIT FED-S

Updated 9/7/2005

#	Name and Description	Allowed Values	Format	Definition	Code
40	children_nbr Number of Children	0-96=Number of Children 97=Unknown	number (2)	Specifies the number of children, age 17 or less, birth or adopted. The children may or may not live with the client.	ADMIT STATE
41	criminal_justice_nbr Number of Arrests at Admission	0-96=Number of Arrests 97=Unknown	number (2)	The number of times the client reports being arrested or cited (including DUI citations and any misdemeanor drug citations) in the six months prior to admission. If the client is not able to report, mark as "unknown."	ADMIT STATE-R
42	last_contact_dt Date of Last Client Contact	Legal Date	mm/dd/yyyy	The month, day and year when the client is last seen, physically, for a treatment service. The date may be the same date as the date of discharge but should not occur after the date of discharge.	DISCH FED
43	discon_dt Date of Client Discontinuation/ Discharge	Legal Date	mm/dd/yyyy	The month, day and year when the client was formally discharged from the treatment facility or service. The date may be the same as the date of last client contact. In the event of a change of service or provider within an episode of treatment, it is the date the service terminated or the date the treatment for this service ended at a particular provider. Unless extenuating circumstances exist, a client should be automatically discharged if the client has not been seen in 5 days in the case of inpatient or residential treatment, 14 days in the case of day treatment and 60 days in the case of outpatient or intensive outpatient.	DISCH FED
44	discharge_reason_cd Discontinuation Reason	1=Treatment Completed 2=Left against professional advice (drop out) 3=Terminated by the facility 4=Transferred to another substance abuse treatment program or service/program type 5=Incarcerated 6=Died 7=Other	number (1)	Indicates the outcome of treatment, the reason for transfer or discontinuance of treatment. <u>Treatment completed:</u> The client has completed his/her treatment <b>episode</b> . In most cases, this should mean that the client has completed at least 75% of their treatment objectives. <u>Terminated by facility:</u> The client was discharged due to facility rule violations, AWOL, criminal behavior, etc. <u>Transferred to another substance abuse treatment program or facility:</u> This code is to be used for all clients who have a change of service or provider within an episode of treatment. This would include a change in modality of service (change to a higher or lower level of care) or a lateral-step due to program expertise.	DISCH FED
45	dis_employment_cd	1=Employed Full Time 2=Employed Part time 3=Unemployed 4=Homemaker 5=Student 6=Retired 7=Disabled 8=Inmate of an Institution 20=Other "Not In the Labor Force" 97Unknown	number (2)	Applies to expected employment status upon leaving treatment. <u>Employed Full Time:</u> Working 35 hours or more each week, including members of the uniformed service. <u>Employed Part Time:</u> Working fewer than 35 hours each week. <u>Unemployed:</u> Looking for work during the past 30 days or on layoff from a job. <u>Inmate of an institution:</u> Prison or an institution that keeps a person, otherwise able, from entering the labor force. <u>Other "Not in the Labor Force":</u> Not looking for work during the past 30 days.	DISCH STATE-R

Updated 3/1/2005

#	Name and Description	Allowed Values	Format	Definition	Code
46	dis_pri_substance_cd Substance Code Primary at Discharge	1=None 2=Alcohol 3=Cocaine/Crack 4=Marijuana/Hashish 5=Heroin 6=Non-Prescription Methadone 7=Other Opiates/Synthetics 8=PCP 9=Other Hallucinogens 10=Methamphetamine 11=Other Amphetamines 12=Other Stimulants 13=Other Benzodiazepines 14=Other Tranquilizers 15=Barbiturates 16=Other Sedatives/Hypnotic 17=Inhalants 18=Over the Counter 30=Oxycodone (Oxycotin, Percocet) 31=LSD 32=Methylphenidate (Ritalin) 33=Alprazolam (Xanax) 34=Diazepam (Valium) 35=Lorazepam (Ativan) 36=Hydrocodone (Vicodin, Lortab) 37=Morphine (ms contin) 38=MDMA (Ecstasy) 39=Rohypnol 40=GHB/GBL 41=Ketamine (Special K) 42=Clonazepam (Klonopin, Rivotril) 20=Other 97=Unknown	number (2)	This should always be the same as the client's substance code primary at admission. For example, if the client's primary substance at admission was marijuana, their primary substance at discharge <b>MUST</b> also be coded as marijuana even if the client is no longer using marijuana or if there is a different substance that they would now consider their primary substance of abuse. For the client that is no longer using their primary substance at admission, this would be noted in the <b>Frequency of Use – Primary at Discharge (Field #48)</b> field (it would be coded as "No Use In the Past Month"). This field should be coded as "unknown" (97) <b>only</b> if the client was admitted into detoxification services and the client left services prior to being capable of providing this information. This field must be coded as "none" (1) if and only if the client was admitted as co-dependent/collateral and his/her <i>Substance Code Primary at Admission</i> was coded as none.	DISCH STATE-R
47	dis_sec_substance_cd Substance Code Secondary at Discharge	Same as Field 46	number (2)	This should always be the same as the client's substance code secondary at admission.	DISCH STATE

#	Name and Description	Allowed Values	Format	Definition	Code
48	dis_pri_frequency_use_cd Frequency of Use - Primary at Discharge	1=No Use During Last 30 Days 2=1-3 Times During Last 30 Days 3=1-2 Times Per Week During Last 30 Days 4=3-6 Times Per Week During Last 30 Days 5=Daily Use During Last 30 Days 7=Unknown 8=Not Applicable	number (1)	Identified the approximate number of times the primary substance of abuse was used in the month prior to discharge. This field should be coded as "unknown" (7) only if the client's <i>Substance Code Primary at Admission</i> was also coded as "unknown" (97). Response can be deduced based on the last known status of the client while in treatment. This field must be coded as "not applicable" (8) if and only if the client's <i>Substance Code Primary at Admission</i> was coded as "none" (1).	DISCH STATE-R
49	dis_sec_frequency_use_cd Frequency of Use - Secondary at Discharge	Same as Field 48	number (1)	Identifies the approximate number of times the secondary substance of abuse was used in the month prior to discharge. This field must be coded as "not applicable" (8) if and only if the client's <i>Substance Code Secondary at Admission</i> was coded as "none" (1).	DISCH STATE
50	dis_living_arrangement_cd Living Arrangement at Discharge	1=Homeless 2=Dependent 3=Independent 7=Unknown	number (1)	Expected living arrangements after discharge. Response can be deduced based on the last known status of the client while in treatment. <u>Homeless</u> : No fixed address, including shelters. <u>Dependent</u> : Clients living in a supervised setting such as a residential institution, halfway house or group home, and children (under age 18) living with parents, relatives, or guardians or in foster care. <u>Independent</u> : Clients living alone or with others without supervision. *The patient should be coded as Dependent if he/she is going into a Dependent setting (including a unit of incarceration) upon being discharged even if he/she has a place of independent residence.	DISCH STATE-R
51	dis_criminal_justice_nbr Number of Arrests at Discharge	0-996=Number of Arrests 997=Unknown	number (3)	The number of times the client reports being arrested or cited (include DUI citations and any misdemeanor drug citations) between the date of admission and the date of discharge. Response can be deduced based on the last known status of the client while in treatment.	DISCH STATE-R



#	Name and Description	Allowed Values	Format	Definition	Code
52	drug_court_cd Drug Court Participation	1=Adult Drug Court 2=Juvenile Drug Court 3=Dependency/Family Drug Court 4=Administrative Drug Board 97Unknown 98=Not Applicable	number (2)	This field is to track the clients who are involved in drug court in some way. <u>Adult Drug Court:</u> clients that are participating in an Adult Drug Court (felony or misdemeanor). <u>Dependency/Family Drug Court:</u> clients that are participating in a Dependency Drug Court. <u>Administrative Drug Board:</u> for Weber and Davis County Parolee's only. <u>Unknown:</u> this is for clients that for some reason it is not known whether they are involved in Drug Court or not. <u>Not Applicable:</u> this is used for clients who are not associated with drug court.	ADMIT STATE-R
53	tobacco_use Tobacco Use	1=Never Used 2=Have Used/Not Current User 3=Occasional User (Less than one cigarette a day) 4=Regular User (Less than two packs a day) 5=Heavy User (Two or more packs a day) 6=Use Smokeless Tobacco Only (In last 30 days) 97Unknown	number (2)	This field is used to track the tobacco (both cigarettes and smokeless tobacco products) usage of treatment clients. If clients use both Cigarettes and Smokeless Tobacco only keep track of the Frequency of Cigarette use. If they only use smokeless tobacco then use the corresponding code. <u>Never Used:</u> for clients that have never used any tobacco products.  <u>Have Used/Not Current User:</u> clients that have used any tobacco product in the past, but have not used in the past thirty days. <u>Occasional User (Less than one cigarette a day):</u> clients that smoke less than one cigarette a day. <u>Regular User (Less than two packs a day):</u> clients that smoke more than one cigarette a day but less than two packs a day. <u>Heavy User (Two of more packs a day):</u> clients that smoke two or more packs of cigarettes a day. <u>Use Smokeless Tobacco Only:</u> clients that do not smoke cigarettes, but have used smokeless tobacco in the last thirty days. <u>Unknown:</u> for some reason the client does not know whether they have ever used tobacco.	ADMIT STATE-R
54	tobacco_age Age of First Use of Tobacco	0-96=Age 97=Unknown 98=Not Applicable	number (2)	This is to collect the age of first use of tobacco for those clients that have ever used tobacco products, including clients that are current users of tobacco products. <u>Age:</u> the codes from 0 to 96 will be allowed for the age that the client first started using any tobacco product. <u>Unknown:</u> this is for clients who for some reason do not know the age when they first started using any tobacco products. <u>Not Applicable:</u> This is the code that will also be used for those clients that never have used tobacco and thus don't have an age of first use.	ADMIT STATE-R

#	Name and Description	Allowed Values	Format	Definition	Code
55	last_name Client Last Name	Last Name of Client 97=Unknown	string (20)	The last name of the client. Please limit the last name to 20 letters. Any names exceeding 20 letters will be reduced in the State database to the first twenty letters.	ADMIT STATE
56	first_name Client First Name	First Name of Client 97=Unknown	string (20)	The first name of the client. Please limit the first name to 20 letters. Any names exceeding 20 letters will be reduced in the State database to the first twenty letters.	ADMIT STATE
57	mid_initial Client Middle Initial	Middle Initial of Client 7=Unknown 8=Not Applicable	string (1)	Middle initial of the client. Use Not Applicable (8) if the client does not have a middle name.	ADMIT STATE
58	family_size Number of Persons in Client's Household	1-9=Number of Persons 10=More than 9 persons in client's household 97=Unknown	number (2)	The total number of persons in the client's legal family with whom he/she lives, <b><u>including the client.</u></b> *The following should be including: parents, children, stepchildren, step-parents, siblings, half-siblings, step-siblings, children in court-ordered custody, and cohabitating partners. The following should be included IF they are dependent upon the household income: grandparents, step-grandparents, grandchildren, step-grandchildren, aunts, uncles, and cousins.	ADMIT STATE
59	family_income Client's household income	Monthly Gross Income 97=Unknown	number (6)	Total of all legal <b>monthly</b> income for the household in which the client lives and is legally a part of. For adolescent clients, include parents'/guardians' income. Do not use commas, decimals, or dollar signs (\$).	ADMIT STATE